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PPACA IMPLEMENTATION FAILURES: WHAT'S NEXT?

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

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PPACA IMPLEMENTATION FAILURES: WHAT'S NEXT?

WEDNESDAY, DECEMBER 11, 2013

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:00 a.m., in room 2123, Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Burgess, Whitfield, Shimkus, Rogers, Murphy, Blackburn, Gingrey, Lance, Cassidy, Guthrie, Griffith, Bilirakis, Ellmers, Barton, Upton (ex officio), Pallone, Dingell, Engel, Schakowsky, Matheson, Green, Barrow, Castor, Sarbanes, and Waxman (ex officio).

Also present: Representative DeGette.

Staff present: Clay Alspach, Counsel, Health; Carl Anderson, Counsel, Oversight; Gary Andres, Staff Director; Ray Baum, Senior Policy Advisor/Director of Coalitions; Sean Bonyun, Communications Director; Matt Bravo, Professional Staff Member; Karen Christian, Chief Counsel, Oversight; Noelle Clemente, Press Secretary; Paul Edattel, Professional Staff Member, Health; Brad Grantz, Policy Coordinator, Oversight and Investigations; Sydne Harwick, Legislative Clerk; Brittany Havens, Legislative Clerk; Sean Hayes, Counsel, Oversight and Investigations; Robert Horne, Professional Staff Member, Health; Alexa Marrero, Deputy Staff Director; Katie Novaria, Legislative Clerk; Monica Popp, Professional Staff Member, Health; Chris Sarley, Policy Coordinator, Environment and the Economy; Heidi Stirrup, Policy Coordinator, Health; Tom Wilbur, Digital Media Advisor; Ziky Ababiya, Democratic Staff Assistant; Phil Barnett, Democratic Staff Director; Stacia Cardille, Democratic Deputy Chief Counsel; Brian Cohen, Democratic Staff Director, Oversight and Investigations, Senior Policy Advisor; Hannah Green, Democratic Staff Assistant; Elizabeth Letter, Democratic Assistant Press Secretary; Karen Nelson, Democratic Deputy Staff Director, Health; Stephen Salsbury, Democratic Special Assistant; and Matt Siegler, Democratic Counsel.

Mr. PITTS. The subcommittee will come to order.

The Chair will recognize himself for an opening statement.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Throughout this year, various administration officials, including you, Madam Secretary, have sat in this room and repeatedly told the American people that implementation of the Affordable Care Act was on schedule.

As we have seen from the disastrous rollout of HealthCare.gov and documents showing that the October 1 deadline could not be met, that was false.

In fact, every major promise the administration made about the ACA, from being able to keep your health plan if you like it, to being able to keep your doctor if you want to, the very premise of health reform in the first place, that the Affordable Care Act would make health coverage more affordable, has proven to be wrong.

My constituents have repeatedly expressed to me that they feel they were lied to by the administration about the real effects of this law.

In addition, we are also learning that millions may be improperly enrolled in Medicaid as a result of the disastrous rollout—resulting in Washington, yet again squandering the hard-earned dollars sent to the Federal Government by our constituents.

Words start to lose their meaning when they are delivered by individuals who have either misled this committee or were woefully ignorant of the disastrous consequences that have unfolded since enactment of the ACA.

The last time you were here, Madam Secretary, you said "I know that it isn't fair to ask the American people to take our word for it."

While millions of Americans are being harmed by this law, my constituents do not trust the administration when it comes to the Affordable Care Act, and it is they who are suffering because of these broken promises.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

Throughout this year, various administration officials, including you, Secretary Sebelius, have sat in this room and repeatedly told the American people that implementation of the Affordable Care Act was on schedule.

As we have seen from the disastrous rollout of healthcare.gov, and documents showing that the October 1 deadline could not be met, that was false.

In fact, every major promise the administration made about the ACA—from being able to keep your health plan if you like it, to being able to keep your doctor if you want to, to the very premise of health reform in the first place, that the ACA would make health coverage more affordable—has proven to be wrong.

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The last time you were here, Madam Secretary, you said, "I know that it isn't fair to ask the American people to take our word for it."

My constituents do not trust the administration when it comes to the ACA, and it is they who are suffering because of these broken promises.

Mr. PITTS. And I will yield to the chairman of the full committee, Mr. Upton.

OPENING STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. UPTON. Thank you, Mr. Chairman. This committee has conducted extensive oversight of the President's health care law. Many of the administration's top health officials have testified over the last year, including the Secretary. They repeatedly looked us in the eye in the spring, summer, and fall, and assured us that in fact everything was on track. But our oversight has produced documents showing the frantic chaos of missed deadlines and delays behind the scenes.

Sadly, it seems that the administration's assurances about being ready to launch were just as empty as the President's promises that this law would mean lower costs while allowing Americans to keep the coverage and doctors that they have and like. And millions of Americans are now enduring the harsh reality of canceled plans, the burden of finding a new doctor and the financial strain of higher premiums set to shock family budgets.

Far too many Americans who are happy and satisfied with their health care coverage on January 1st of this year have had their worlds turned upside down as we approach January 1st of 2014.

This is a matter of trust. It is time for the administration to be honest with folks like Mary Swanson in Kalamazoo, Michigan, my constituent, who, along with her husband, has lost a self-described excellent plan. No more false promises, no more political games, no more questionable testimony, it is time for transparency and the truth, and I yield the balance of my time to Dr. Murphy.

[The prepared statement of Mr. Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON

This committee has conducted extensive oversight of the president's health care law. Many of the administration's top health officials have testified over the last year, including the secretary. They repeatedly looked us in the eye—in the spring, summer, and fall—and assured us everything was "on track." But our oversight has produced documents showing the frantic chaos of missed deadlines and delays behind the scenes.

Sadly, it seems the administration's assurances about being ready to launch were just as empty as the president's promises that this law would mean lower costs while allowing Americans to keep the coverage and doctors they have and like. Millions of Americans are now enduring the harsh reality of canceled plans, the burden of finding a new doctor, and the financial strain of higher premiums set to shock family budgets. Far too many Americans who were happy and satisfied with their health coverage on January 1, 2013, have had their worlds turned upside down as we approach January 1, 2014.

This is a matter of trust. It is time for the administration to be honest with folks like Mary Swanson in Kalamazoo, Michigan, who along with her husband has lost a self-described "excellent" plan. No more false promises. No more political games. No more questionable testimony. It is time for transparency and the truth.

OPENING STATEMENT OF HON. TIM MUPRHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY. Thank you, Chairman Upton. And thank you for being here today, Secretary Sebelius.

As the chairman of the Subcommittee on Oversight and Investigations, I worked with my fellow members to conduct oversight of the President's health care law. We have had several people before our committee who have talked about its implementation. Some of the concerns and questions you raised in the first part of this year, increased premiums, the burden of this law on small businesses, whether the implementation was on track and the costs have come to fruition.

Documents uncovered by the O&I Subcommittee show that the administration knew months before the October 1 start-up of open enrollment about problems with the Federally facilitated marketplace. And yet every administration official came before us testified before the committee this year that implementation was on track.

Now we are just 2 weeks away from the January 1 start of coverage, and what should the American public expect? Unfortunately, the record of transparency has not improved. The administration has continued its pattern of announcing delays to the law over the holiday weekend, most recently the 1-year delay of the online enrollment to the SHOP program. And it failed to acknowledge problems when the writing is on the wall. In the meantime, millions have received a pink slip from their insurance plan, and others are facing unaffordable care with new higher rates.

Last month, a top CMS official told the committee that 30 to 40 percent of the Web site was yet to be built. I hope you will be able to provide, get some answers for us today. I hope you also commit today to help speed up the response to the committee's document request. Two boxes of documents in 2 months is not a good response. Thank you.

Mr. PITTS. The Chair thanks the gentleman. The Chair now recognizes the ranking member of the subcommittee, Mr. Pallone, 5 minutes.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Chairman Pitts. Let me just say that I'm sorry that you couldn't find a way to accommodate members to attend the Nelson Mandela memorial and not miss today's important hearing. Many of the Democrats are at that memorial service today, and I know that Mr. Waxman made a reasonable request that was denied, and I wish that it hadn't been the case. But in any case, we are moving forward. I listened to what my Republican colleagues just said about the Affordable Care Act, and Madam Secretary, and I don't know where the reality is on their part. Sometimes I think that they are living on Mars rather than Earth. I heard consequences, things like disastrous consequences, harm, suffering, harsh reality, world turned upside down.

I mean, they should have been at my forum. I had a forum Monday night in Highland Park which is one of my towns, on the ACA, and I heard just the opposite. People were happy because they were able to enroll. Some were Medicaid recipients who weren't eligible for Medicaid before. Many of them, you know, were remarking about, you know, the ability to get insurance for the first time.

So you know it just boggles my mind to hear these Republican comments about a world turned upside down when the reality is that the Affordable Care Act is working. People are getting insurance who didn't have it, people are getting affordable insurance with good benefits. I mean, that is the reality that I hear when I am home, and I am not making it up. I mean, I will take any of them to my forum if they want to.

Regardless, let me welcome you, Madam Secretary, for joining us again. I understand you have been in front of our committee more than any other and we are grateful for your service and your valuable time. I am eager to hear what I know is positive news about the enrollment of coverage under the ACA and the law's implementation. Republicans seem to be saying things haven't improved. They have improved a lot, and certainly the Web site has improved a lot. It is really unfortunate that the Republicans continue to focus their time and effort trying to obstruct and sabotage the ACA rather than working on a constructive way to make sure that as many Americans as possible are able to benefit from it.

I am proud of this law. And I wanted to mention a story, one of my constituents from Piscataway, New Jersey, wrote a letter to the editor of a local newspaper describing his experience with health insurance pre and post implementation of the health exchange, and I ask that the letter be submitted for the record, Mr. Chairman.

Mr. PITTS. Without objection, so ordered.

[The information follows:]

11/18/13: Anthony Weil, Letter To The Editor: "I Bought A Plan That Costs Less Than What That 50 Percent -Increase Insurer Had Offered Me For 2013, And It Had Better Coverage, A Better Deductible, A Better Out-Of-Pocket Max, Better Co-Pays, A Better Prescription Plan... So If You're Reading This, Don't Let The Troubled Site Hold You Back. Keep Trying. You Won't Regret It."

"I retired in 2007 and paid for a private -insurance plan from 2009 to 2013. In 2012, I was paying about $800 per month. And in 2013, my insurance company sent me a letter saying that they were raising my premium by nearly 50 percent to almost $1,200 per month. I'd be paying almost $400 more per month for the same plan. I was pretty upset. I knew I had enough money to get by, but a 50 percent increase was going to make things tight. I had to make a choice; pay an exorbitant premium, which would seriously impact my finances, or downsize my insurance plan. So I dropped them and joined what I call a 'catastrophic plan' just to have some type of security...But I knew Obamacare was coming. I was waiting for it. So when enrollment started at midnight on Oct. 1, I was on healthcare.gov at 1 a.m. As I said before, the site takes patience. I was frustrated at first, but I wanted it to work. So I kept trying. And when I got in and completed my application on Oct. 5, I was delighted by the options and premiums. I bought a plan that costs less than what that 50 percent-increase insurer had offered me for 2013, and it had better coverage, a better deductible, a better out-of-pocket max, better co-pays, a better prescription plan. It was just better. I got a lot more for a lot less. I'd been suffering every year watching my premiums rise until I was tiptoeing around trying to dodge sickness. And that's all over now. So if you're reading this, don't let the troubled site hold you back. Keep trying. You won't regret it ... Anthony Weil PISCATAWAY."

[Courier News (Bridgewater, NJ), 11/18/13

Mr. PALLONE. I won't read it, but this gentleman found a plan on the exchange that cost less than the price of his previous plan. It has better coverage, better deductible, better out-of-pocket maximum, better copays, better prescription drugs. His experience demonstrates that this is a quality product that people want to sign up for. I will leave it at that because I am yielding now to Mr. Waxman.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you very much for yielding to me. I want to echo your statement about the regrets that we have that the majority wouldn't postpone this hearing so that all members could attend the memorial for Nelson Mandela.

Obviously, more Democrats feel that the reason they wanted to be there was more important than to be here. They shouldn't have had to make that choice. Madam Secretary, I want to welcome you back to our committee.

HealthCare.gov is much improved since you last appeared before the committee. Millions more have applied for coverage and signed up. In fact, we just learned today that enrollment in November quadrupled over the October enrollment.

All told, as of November 30, 365,000 people have enrolled in private coverage, 1.9 million were through the process just waiting to pick a plan, andenrollment has been speeding up each and every week. As a result, we are beginning to hear the stories of people finally getting the security and peace of mind that comes with quality health insurance. And some of these stories are very powerful. Barbara from my district recently found out that her policy was going to be canceled, and she had been rejected in the past for more affordable policies because of her back problem. In a new policy she obtained on the exchange, her deductibles were cut in half, she will save hundreds more on free preventive care, and her premiums will never shoot up if she has a serious health event.

These success stories are happening in every State and district in the country, though you wouldn't know it from the Republican members' comments. Joanne from Florida had been uninsured and hadn't seen a doctor in years. She has repeatedly tried to enroll without success, and then this week, she purchased a plan for only a few dollars a month. When that finely occurred, she burst into tears. Our exchange director in California has said that this is a common experience.

I know this law is controversial, Mr. Chairman, that is because of hundreds of millions of dollars, opponents have spent trying to demonize the law. I think Republicans are afraid that this law is going to be popular when it is fully in effect. The public is tired of the partisanship from a divided Congress. Mr. Chairman, I want to make one request, and this will be the last statement I want to make now. I hope that the Secretary gets more respectful treatment from all the members than she received in the last hearing. At a minimum, she should be allowed to answer questions. The last time she was interrupted over and over again.

There are more Republicans here today than Democrats. We are all going to get our chance to ask questions, a lot of Democrats won't because they chose to be at the memorial service, but whoever asks the question, the Secretary should be able to answer her questions and not be rudely interrupted and not have the cheap shots she had to endure the last time.

Mr. PITTS. The Chair thanks the gentleman. The gentleman's time is expired.

Without objection, all members' opening statements will be made a part of the record.

On our panel today, we have the Honorable Kathleen Sebelius, the Secretary of the Department of Health & Human Services. Thank you again, Madam Secretary, for coming. I urge all members to use proper decorum and permit her to respond to the questions. But we only have so many minutes. I understand members will be trying to get as many questions in as they possibly can, and we will try to operate the gavel strictly and fairly.

Madam Secretary, thank you for coming. You will have 5 minutes to summarize your testimony. Your written testimony will be placed in the record. At this time the Chair recognizes the Honorable Secretary Sebelius, 5 minutes.

STATEMENT OF KATHLEEN SEBELIUS, SECRETARY, DEPARTMENT OF HEALTH & HUMAN SERVICES

Ms. SEBELIUS. Well, thank you, Chairman Upton and Ranking Member Waxman, Mr. Pitts, Mr. Pallone, members of the committee, since I was last here on October 30th, our team has been working around the clock to improve HealthCare.gov. We committed to making the site work smoothly for the vast majority of users by the end of November, and after several hundred software fixes and hardware upgrades, we have achieved this first benchmark.

While there is still more work to do, we have made great progress. HealthCare.gov is working faster, responding more quickly and we are able to handle larger volumes of concurrent users. Pages that once took 8 seconds to load are now responding in under a second. The site's error rate which once topped 6 percent has been driven down to below 1 percent. The system has more redundancy and stability, and we can now handle 50,000 simultaneous users and more than 800,000 daily visitors.

Now as more Americans give HealthCare.gov a second look, they are finding the experience is night and day compared to where we were back in October. And they are responding by shopping for plans and enrolling in greater numbers. As Mr. Waxman has said, more than four times as many enrolled in the Federal marketplace in November as enrolled in October.

In the first 2 months, nearly 1.2 million Americans either selected a marketplace plan or received a Medicaid or CHIP eligibility determination with nearly 365,000 people selecting a plan and 803,000 receiving a determination.

An additional 1.9 million people have made it through the application and determination, but have not yet selected a plan, and we expect that as more folks talk things over with their families and learn about their new options, more will enroll. To those who have

been frustrated with the experience so far, we are asking you to come back.

It is now easier than ever to shop for plans and enroll on line, over the phone, on paper, in person or directly through an issuer or agent. More than 5 million Americans have dialed into our call center in the first 2 months, 450,000 have received assistance from more than 19,000 trained assisters. And in the first week of December alone, HealthCare.gov received nearly 5 million visits.

Open enrollment for health insurance continues for 3–1/2 more months, so there is still time. To put this in perspective, most private insurance plans offer open enrollment for only a few weeks.

Now we continue to be relentless in our efforts to improve HealthCare.gov, and we are committed to learning, adapting, improving and acting on the feedback we received from consumers and issuers alike. As I told this committee at the end of October, the initial launch of HealthCare.gov was flawed, frustrating and unacceptable. And I believe strongly in accountability and our obligations as public servants to be good stewards of taxpayer dollars.

Now that the Web site is working more smoothly, I have determined it is the right time to begin a process of understanding the structural and managerial policies that led to the flawed launch so we can take action and avoid these problems in the future.

Today I am announcing some initial steps I have taken. I have asked our inspector general, Dan Levinson, to investigate the development of HealthCare.gov including contractor acquisition, the overall management of the project and performance and payment of our contractors. I have asked CMS Administrator Marilyn Tavenner to create a new position of chief risk officer at the Centers for Medicare & Medicaid Services and to expedite the search and hiring. This will be a full-time employee charged with assessing risk management practices and developing strategies to minimize those risks.

And let me be specific. I will instruct this officer to look at IT and contracting management practices starting with HealthCare.gov and the risk factors that impeded a successful launch. I will ask for an initial report in the first 60 days with recommendations on how we can mitigate risk as we move forward. And I have instructed CMS to update and expand their employee training, they will be required to adopt best practices for contractor and procurement management, rules and procedures, including internal communications and processes. These actions build on reforms we have already made which have led to significant improvements in the Web site. It includes the addition of Jeff Zients as the management expert and consultant to Administrator Tavenner and me, selecting QSSI as the systems integrator and changing the day-to-day CMS management of HealthCare.gov.

Fixing a flawed Web site has proven challenging, but it is nothing compared to the challenges that American families face every day, particularly those families who don't yet have health coverage, families who are one medical bill away from bankruptcy, one diagnosis away from not being able to afford their mortgage or their rent. And these efforts are about them. Before the Affordable Care Act, as many as 14,000 of our neighbors were losing their coverage

each and every day. The market operated inefficiently, we as a Nation paid more and got lower health results.

Today, health care cost growth has been driven down to the lowest levels in 50 years, and millions of Americans are already benefiting from new rights and consumer protections. With the new marketplace, choice and competition among private market plans is now available to millions of Americans. But our work is not done until every eligible American has the opportunity to access affordable coverage.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Sebelius follows:]

STATEMENT OF

KATHLEEN SEBELIUS

SECRETARY

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

ON

AFFORDABLE CARE ACT IMPLEMENTATION

BEFORE THE

U. S. HOUSE ENERGY & COMMERCE COMMITTEE
SUBCOMMITTEE ON HEALTH

DECEMBER 11, 2013

Testimony of Kathleen Sebelius
U.S. Department of Health and Human Services
on Affordable Care Act Implementation
House Committee on Energy & Commerce
Subcommittee on Health
December 11, 2013

Good morning, Chairman Pitts, Ranking Member Pallone, Chairman Upton, Ranking Member Waxman, and Members of the Committee. On October 1st, we launched one of the key provisions of the Affordable Care Act—the new Health Insurance Marketplace, where people without health insurance, including those who cannot afford health insurance, and those who are not part of a group plan, can go to get affordable, quality health coverage. Consumers can access the Marketplace in several ways—through a call center, by filling out a paper application, with the help of in-person assistance, or by going online and filling out an application on HealthCare.gov.

Improvements Made to HealthCare.gov

In October, far too many consumers who visited HealthCare.gov had an unacceptable user experience. Consumers were experiencing slow response times and frequent, inexplicable error messages. The website experienced frequent unplanned outages.

In mid-October, we conducted an assessment of the site HealthCare.gov. The assessment was conducted by experts from across the government and private sector. The assessment determined that the root causes for the site's flaws included hundreds of software bugs and insufficient hardware and infrastructure. The system monitoring and response mechanisms were not sufficient for identifying issues or bugs or responding to them in real time. The team identified the problems and necessary fixes and determined that HealthCare.gov was fixable through significant technical improvements, changes to the management approach, and a relentless focus on execution of necessary improvements.

Improving the user experience for HealthCare.gov required a deeper real-time analysis of the system, additional technical expertise, and a strong management structure to prioritize and develop metrics for system fixes. The Centers for Medicare and Medicaid Services (CMS) appointed QSSI – with its deep management expertise – as the General Contractor and Systems Integrator to coordinate all activities with CMS and other contractors. With one central command structure and a more streamlined process for facilitating real-time, data-based decision making, the team has implemented high-performance management practices and completed high-priority fixes.

Newly-installed technical monitoring instruments have allowed for constant, real-time analysis of site performance. With this new management structure and continuous data on the performance of the system, the team now has the capacity to rapidly respond to any incidents and to better understand root causes.

Over the last five weeks, we have made substantial progress in improving HealthCare.gov and getting the system to where it needs to be: hundreds of software fixes, hardware upgrades and continuous monitoring have measurably improved the consumer experience; site capacity is stable at its intended level; operating metrics are greatly improved; and high activity levels demonstrate the site is working for the vast majority of consumers.

While there is more work to be done, the team is operating with velocity and effectiveness that matches high performing private sector organizations. The team will continue to improve and enhance the website in the weeks and months ahead.

The new management system and instrumentation have helped improve site stability, lower the error rate to less than 1 percent, increase capacity to allow 50,000 concurrent users to simultaneously use the site and for 800,000 or more consumers to visit the site daily, and will help drive continuous improvement on the site. While we strive to innovate and improve our outreach to consumers, we believe we have created a system that now works smoothly for the vast majority of Americans seeking quality, affordable healthcare coverage.

Expanding Access to Affordable Coverage through the Health Insurance Marketplace

The new Marketplace enables people without health insurance, including those who cannot afford health insurance and those who are not part of a group plan, to finally start getting quality, affordable coverage.

The idea of the Marketplace is simple. By enrolling in private health insurance through the Marketplace, consumers effectively become part of a statewide group that spreads risk between sick people and healthy people and between young and old. Because we have created competition where there was not competition before, insurers are eager for new business, and have created new health care plans with more choices and affordable premiums.

During the first reporting period of the Health Insurance Marketplace's Open Enrollment, which spanned October 1 through November 2, 106,185 individuals selected plans from the Marketplace, and another 975,407 had applied and received an eligibility determination, but had not yet selected a plan.

In addition to the more affordable rates resulting from competition among insurers, insurance affordability programs, including premium tax credits and cost-sharing reductions, will help significantly reduce the monthly premiums and cost-sharing paid by many eligible individuals and families. Premium tax credits may be paid in advance and applied to the purchase of a qualified health plan through the Marketplace, enabling consumers to reduce the upfront cost of purchasing insurance. The cost-sharing reductions will lower out-of-pocket payments for deductibles, coinsurance, and copayments for many of these consumers. A recent RAND report[1] indicated that, for the average Marketplace participant nationwide, the premium tax credits will reduce out-of-pocket premium costs by 35 percent from their unsubsidized levels.[2]

CBO has projected that about eight in 10 Americans who obtain coverage through the Marketplace will qualify for assistance to make their insurance more affordable, an estimated

[1] http://www.rand.org/content/dam/rand/pubs/research_reports/RR100/RR189/RAND_RR189.pdf
[2] This is a simple calculation based on Figure 6 of the RAND study, available at the link above.

20 million Americans by 2017.[3] A family's eligibility for these affordability programs depends on its family size, household income, and access to other types of health coverage.

Other Benefits of the Affordable Care Act

It is important to remember that the Affordable Care Act does much more than make affordable insurance available through HealthCare.gov. Most Americans—85 percent—already have health coverage through an employer-based plan or a public program such as Medicare, Medicaid, or the Children's Health Insurance Program (CHIP). For these Americans, the Affordable Care Act provides new benefits and protections, many of which have been in place for some time. For example, because of the Affordable Care Act, 3.1 million young adults have gained coverage through their parents' plans. Since the Affordable Care Act was enacted, more than 7.3 million seniors and people with disabilities who reached the coverage gap—known as the "donut hole"—in their Medicare Part D (Medicare Prescription Drug Coverage) plans have saved $8.9 billion on their prescription drugs, an average of $1,209 per person since the program began. During the first 10 months of 2013, nearly 3.4 million people nationwide who reached the donut hole have saved $2.9 billion, an average of $866 per beneficiary. These figures are higher than at this same point last year, when 2.8 million beneficiaries had saved $1.8 billion for an average of $677 per beneficiary. Because of the Affordable Care Act, millions of Americans can receive recommended preventive care like mammograms at no additional cost. The law has made it illegal for health insurance companies to simply deny insurance to any applicant with a pre-existing condition. And insurers cannot charge any more for that applicants' health insurance than they would any healthy applicant.

Last week, we released a report showing that over 1.46 million people were determined eligible to enroll in Medicaid or CHIP in the month of October through state Medicaid and CHIP agencies and through State-based Marketplaces. Since October 1, when the new Health Insurance Marketplaces opened, we've been hearing about those who are enrolling in Medicaid and CHIP coverage every day. In October, in states that are fully participating in the expansion

[3] http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf

of Medicaid coverage made possible by the law, we've seen a more than 15 percent jump in applications compared to the average monthly enrollment in July through September. In Oregon, for example, a Medicaid eligibility expansion will help cut the number of uninsured people by 10 percent. As a result of the state's enrollment efforts over the last few weeks, 56,000 more Americans will now have access to affordable health care. This shows that low-income Americans have a real need and desire for coverage.

The Affordable Care Act is also holding insurers accountable for the rates they charge consumers. For example, insurance companies are now required to justify a rate increase of 10 percent or more, shedding light on unnecessary costs. Since this rule was implemented,[4] the proportion of rate filings requesting insurance premium increases of 10 percent or more has plummeted from 75 percent in 2010[5] to an estimated 14 percent in the first quarter of 2013,[6] saving Americans an estimated $1.2 billion on their health insurance premiums.[7] These figures strongly suggest the effectiveness of review of rate increases.

The rate-review program works in conjunction with the so-called 80/20 rule (or Medical Loss Ratio rule),[8] which generally requires insurance companies in the individual and small group markets to spend at least 80 percent of premiums on health care and quality improvement activities and no more than 20 percent on administrative costs (such as executive salaries and marketing) and profits. In the large group market (generally coverage sold to employers with more than 50 employees), insurers must spend at least 85 percent of premiums on medical care and quality improvement activities. If insurers fail to meet their medical loss ratio requirement, they must provide rebates to their customers.

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[4] Health Insurance Rate Review – Final Rule on Rate Increase Disclosure and Review: http://www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf

[5] http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/rate-review09112012a.html

[6] http://aspe.hhs.gov/health/reports/2013/rateIncreaseIndvMkt/rb.cfm

[7] http://aspe.hhs.gov/health/reports/2013/acaannualreport/ratereview_rpt.cfm

[8] Medical Loss Ratio Final Rule: https://www.federalregister.gov/articles/2012/05/16/2012-11753/medical-loss-ratio-requirements-under-the-patient-protection-and-affordable-care-act

New rules will help make health insurance even more affordable for more Americans beginning next year.[9] Individual and small employer health insurance plans will be prohibited from charging higher premiums to applicants because of their current or past health problems or gender, and will be limited in how much more they can charge Americans based on age.

Conclusion

The Affordable Care Act is more than a website. In addition to offering uninsured Americans affordable coverage options starting in 2014, the law has already provided new benefits and protections to Americans with health insurance. We are committed to continually improving the experience for consumers using HealthCare.gov so that Americans can easily access the quality, affordable health coverage they need, and that the Affordable Care Act fully delivers on its promise.

[9] Health Insurance Market Rules: http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf

Mr. PITTS. The Chair thanks the gentlelady. I will begin questioning and recognize myself 5 minutes for that purpose.

Madam Secretary, based on current trends, it is likely that more individuals will have lost coverage on January 1st than will have gained it under the law. HHS released data this morning stating that approximately 364,000 Americans have selected a plan through a State or a Federal exchange. Is that correct?

Ms. SEBELIUS. Yes, sir.

Mr. PITTS. Of these 364,000 Americans, do you know how many of those individuals will actually have coverage in effect on January 1, 2014?

Ms. SEBELIUS. Sir, once they pay their premium, they will have coverage in effect.

Mr. PITTS. So you don't know. These are the ones who have just selected plan but haven't paid their first payment on the premium?

Ms. SEBELIUS. Some may have paid, some may not. We are giving you the enrollment numbers.

Mr. PITTS. Do you even—this is a critical statistic, it is clear HHS knows the number of Americans who essentially have put a plan in their shopping cart. Your testimony includes data on the number of users who can use HealthCare.gov simultaneously and the number of Web site hits. However, this most critical statistic, the number of Americans who will actually have coverage effective January 1, do you have an estimate?

Ms. SEBELIUS. Sir, I think 365,000 through the end of November have enrolled in coverage, and we are dealing with the issuers to confirm their actual payment.

Mr. PITTS. Would you define "enrollment"? Define what you mean by "enrollment."

Ms. SEBELIUS. We are giving you the numbers of individuals who have chosen a plan.

Mr. PITTS. But not actually paid their first premium——

Ms. SEBELIUS. That is correct.

Mr. PITTS [continuing]. Or received a card?

Ms. SEBELIUS. Through the end of November, yes. Payment isn't due as you know, sir, until mid December in order to be fully covered. So we don't have those numbers, and I think most Americans probably will not pay until their money is owed.

Mr. PITTS. So you can't guarantee the actual number of constituents who have coverage that they——

Ms. SEBELIUS. Not until they pay their premium.

Mr. PITTS. In October, the AP reported that a September 5 memo sent to you listed monthly enrollment targets for the exchanges, and this memo indicates that your target enrollment number for the end of December is 3.3 million. Based on HHS' release this morning, your Department is more than 3 million off their target number, isn't that correct?

Ms. SEBELIUS. Through the end of November, that is correct, sir.

Mr. PITTS. Some news reports have indicated that as many as 5.6 million individuals have had their policy canceled. Isn't it the case that on January 1, more Americans will have their coverage canceled than will have enrolled in an exchange?

Ms. SEBELIUS. Well, sir, I don't know where the 5 million number comes from. I know people have been told that their health plan

doesn't necessarily match the ACA compliant plans. They are not in a grandfathered plan, and a number of those individuals have already re-enlisted and enrolled in plans. So losing coverage and being notified that the plan that they had doesn't exist anymore are two very different things.

Mr. PITTS. Now much like the millions of cancelations in the individual market, the Affordable Care Act requires group coverage to also comply with HHS standards, and many of these plans could be canceled next year as well.

Madam Secretary, the issue with the canceled plans and the President's broken promise that if you like it you can keep it, this is because some of those individual plans did not comply with the health care law's 2014 requirements, correct?

Ms. SEBELIUS. That is true, sir, or they did not stay in a grandfathered plan. What the law said from the outset is if insurers left the plan in place that an individual had in March of 2010, and there are millions of Americans who are in those grandfathered plans, that the plan stayed in effect through the implementation of the Affordable Care Act.

Mr. PITTS. Now, what about small group market plans used by small businesses and their employees. Don't these have to comply with the ACA standards?

Ms. SEBELIUS. In the same way. If the grandfathered plans stayed in effect, they could still be in effect. If not, the consumer protections that are available through the Affordable Care Act would come into play.

Mr. PITTS. Could some small group plans be canceled because they do not comply with the ACA?

Ms. SEBELIUS. Yes, sir. And, again, insurers cancel plans each and every year. They change plans, they change networks. That is part of the market strategy.

Mr. PITTS. Madam Secretary, before passage of the health care law, President Obama routinely promised that the average family would save over $2,000 on their premiums. Would you agree today that this simply is not true, every family will see premium decreases? Some will see increases? Yes?

Ms. SEBELIUS. Well, Mr. Pitts, I think that the President talked about health care costs going down for Americans. I think that we have adequately documented that health care costs, indeed, have gone down based on the trajectory that we would have seen, absent the Affordable Care Act, underlying health costs are rising at the lowest rate in 50 years, Medicare costs have risen at this lowest rate, Medicaid costs have actually come down per capita throughout the country, and private insurance rates are rising at the lowest level that they have in decades. So Americans are seeing a very different cost trajectory than they would have absent the passage of the Affordable Care Act.

Mr. PITTS. My time is expired. Thank you, Madam Secretary, for your responses. The Chair now recognizes the ranking member Mr. Pallone 5 minutes for questioning.

Mr. PALLONE. Thank you, Mr. Chairman, and again, Madam Secretary, I don't want to keep beating a dead horse here but this whole idea that we hear from the Republicans that the world is turned upside down and this, ACA is a disaster is just the opposite.

As you point out, health care costs you know are going down, rates are rising at a less of a level. This whole idea of the President saying if you like it, you can keep it, I mean the President didn't say that if you had a lousy health insurance policy that didn't cover everything that he was to suggesting that insurance companies continue to sell it and therefore you buy it. I was at the Rules Committee the other day when the President issued his executive order, and I had one of my colleagues from Florida, one of my Republican colleagues, talk about how his constituents should be able, should have the freedom, she used the word "freedom," to keep his or her health plan that cost $60 a month. And I asked, well, what is this health plan? It didn't include hospitalization. I don't think the President meant that you should have the freedom to keep a health insurance plan that didn't include hospitalization, I mean, if you want it, his executive order says you can do it, but I think it is absurd to keep arguing over these lousy skeletal plans.

In any case, the reality is that enrollment is accelerating, and I wanted to ask you about enrollment. The numbers released today are impressive, and I wanted to get some broader context from you on how enrollment is progressing. We always expected enrollment to be slow in the early months, and that is what happened in Massachusetts when they implemented the health care reform. In the first month, only .03 percent of people in Massachusetts who ultimately signed up actually enrolled. But the clear trend in the report released today in the reports from the States is that enrollment is surging. In November, there were four times more enrollments in private plans than in October, more than 1.2 million enrolled in private plans that were found eligible for Medicaid, and more than 1.9 million people were eligible for marketplace coverage, employees were enrolled as soon as they select the plan, 3.7 million have applied for coverage. But the most important fact is the trend, the pace of enrollments at the end of the month was double the pace at the start of the month, and that trend appears to be continuing.

Press reports have indicated that more people have signed up for private coverage through the Federal marketplace on November 30th and December 1st than signed up for all of October. Another press report noted that more people selected a plan in the first week of December than selected one in the whole of November.

These are exciting signs. So just given the technical issues we have had and the corresponding delays in much of the outreach campaigns, how would you measure the progress at this point in terms of enrollment?

Ms. SEBELIUS. Well, Mr. Pallone, I don't think there is any question that the flawed launch of the Web site put a damper on people's enthusiasm about early sign-up. We had a lot of visitors early on who got very frustrated and have not reengaged. We have been inviting them back to use a newly improved site, and we are seeing some very, very positive trends in that direction.

So I don't want to minimize the dampening effect that the flawed technology has, not just on the Federal Web site, but I think on news reports also, I think dampened enthusiasm at the State level. It was hard for California, for instance, to ensure people that their

site was fine while there was a lot of news day in and day out about the flawed site.

Having said that, we are seeing very, very positive trends. We are seeing a lot of people reengage. And it is about not only just the numbers of individuals, but at the end of the day, hopefully getting the right mix of individuals and we know that a lot of younger Americans are very tech savvy, want a fully functioning, easy-to-operate site and so getting HealthCare.gov up and running correctly also helps with some of these targeted numbers.

Mr. PALLONE. I appreciate that. Let me just say, I only got 50 seconds here, at my forum, as I said, which was very successful in Highland Park and people were happy with what we were doing the other night, they were particularly pleased that you had that option where you didn't have to, you know, basically provide all your information, but could comparison shop without actually enrolling. I thought that was very good.

And still do encourage people to use alternatives. I know you are right, a lot of people like to use the Web site. But I know there were a lot of people at my forum who were, you know, calling the 800 number, going to community health centers, and also we had some insurance agents and brokers there, and I think that I notice that there is, I think we should encourage that as well as alternatives.

Ms. SEBELIUS. We have been conducting some pilots with a large number of insureds in key States. I think they have gone extremely well. We are encouraging insurance companies to have their agents and brokers directly enroll, and I think that experience has been very productive and we are working closely with them on the kind of technology fixes that they would find most effective.

Mr. PALLONE. Thank you. Thank you, Mr. Chairman.

Mr. PITTS. Thank you, Madam Secretary. The Chair now recognizes the chairman of the full committee, Mr. Upton, 5 minutes for questioning.

Mr. UPTON. Well, thank you, Mr. Chairman. So the goal was to enroll 7 million Americans by the end of March, 365,000 folks enrolled through the end of November, premiums are due beginning mid December. I wonder, Madam Secretary, if you could tell us after Christmas somewhere between Christmas and New Year's as to how many people actually do pay the premium that is due, if you could share that number during the Christmas break with us.

Would that be possible if you could get a number mid December?

Ms. SEBELIUS. Chairman Upton, we—the deadline to enroll is the 23rd, the deadline to pay is the end of the year, so we will not have a number until some time in early January.

Mr. UPTON. So the first of the year? Can you let us know that first week as to how many people actually paid?

Ms. SEBELIUS. I will let you know as soon as we have the numbers, sir.

Mr. UPTON. You indicated to Mr. Pallone that, in fact, the launch was flawed. Knowing what you know today, do you wish, in fact, that you had delayed the launch beyond October 1st?

Ms. SEBELIUS. Well, I certainly wish we could have saved millions of people a very frustrating experience and had a smoother technology launch. I acted on the best information that I had. And

going forward, I think that having an 8-week delay in a fully functioning site is enormously frustrating to millions of Americans and their families.

Having said that, I think there are millions of people who are going to begin receiving health coverage that they never had January 1st and into the new year, and so on balance, I am not sure what the right answer is. The law's benefits went into effect January 1st. People needed some time to sort out options. We clearly put a dent in that time, but there are going to be millions of Americans with new health coverage, and that will continue on into the new year.

Mr. UPTON. So knowing what you know today, you would have started the launch October 1?

Ms. SEBELIUS. I would have probably done a slower launch maybe with fewer people and done some additional beta testing, which is part of what has happened, frankly, in the early months of the launch to identify what problems we had.

Mr. UPTON. So let me go a little deeper. So what grade, if you could give yourself, not you, but HHS, the grading of the launch from A to E or incomplete what would you give the——

Ms. SEBELIUS. Mr. Chairman, I have already said that I think the launch was flawed and failed and frustrating for millions of people. Unacceptable, we want to both figure out exactly the chain of events, what went wrong, which is why I have asked the Inspector General help do this investigation. We have made some changes.

And what we are doing is moving forward. We want to make sure that the millions of people who are eager for affordable health coverage have that opportunity before March 31.

Mr. UPTON. So you announced the IG investigation yesterday. Do you wish that you had started that maybe this summer asking some tough questions in terms of where things were knowing what you knew back then?

Ms. SEBELIUS. I didn't have cause to ask the IG to be involved last summer, no, sir.

Mr. UPTON. The day after Thanksgiving, the administration announced that States would be permitted to use incomplete enrollment information to sign people up for Medicaid. Is it possible that by using incomplete enrollment information, States could be enrolling folks the most vulnerable, by the way, for Medicaid who are not actually eligible?

Ms. SEBELIUS. Sir, we are working very closely with States around Medicaid eligibility, making determinations based on States' specific laws which they have an opportunity to sign off on. So when someone presents at the Web site, and we review their eligibility criteria based on the law of Michigan, we determine preliminary eligibility and send that file to the State.

At the same time the State is doing the same thing for people from Michigan who may come to the State Medicaid office thinking that they are Medicaid eligible and are determined to be marketplace eligible they are returning the files to us.

Mr. UPTON. But the information is incomplete, is it not?

Ms. SEBELIUS. Sir, I am not sure what you are referring to. We are gathering data and information and eligibility. And again, the

State makes the determination based on their State law and based on the information that we have selected.

Mr. UPTON. So are income and residency requirements a part of that information that has to be verified?

Ms. SEBELIUS. I am sorry incoming——

Mr. UPTON. Income and residency.

Ms. SEBELIUS. Yes, sir. The State again makes the final Medicaid determination. We make the preliminary determination and send an individual to the State. If the State doesn't confirm that they meet those requirements, they will not enroll the individual. We have now, as of last night, again, got the systems automated so these files will be sent automated, but we are also sending what we call flat paper files with full information to the States and working one at a time with States, particularly those States like Michigan which has expanded Medicaid for their population to make sure that the data is verified. By the State makes the final Medicaid determination, not the Federal Government.

Mr. PITTS. Thank you, Madam Secretary. The Chair now recognizes the ranking member of the full committee, Mr. Waxman, 5 minutes for questioning.

Mr. WAXMAN. Thank you very much, Mr. Chairman.

I know that there is a lot of politics around this issue. And I certainly understand that changing to a system that is more fair and stable for every American, not just a few, but every American, is not easy. But all of this is exacerbated by wild propagandists' politicized statements that have been made. Even today, the chairman said more people will have lost their coverage than will get coverage. Well, that absolutely cannot be true. It is not true. The Congressional Budget Office, which is not Democratic or Republican, it is nonpartisan, they estimated that 7 million people will sign up for health insurance in the first year, and that 25 million people will be newly insured in 2016. That is really a major accomplishment.

Now we hear Republicans saying more people are losing their policies. But who are those people? We hear estimates that 80 million people will lose their insurance. When you look at that statement, they are saying that people who have a change in their policy have lost it. For example, when they get free preventive services now covered, oh, that means they are losing the policy they had. Or if young adults can stay on that policy up to age 26, Republicans say see they are losing that policy. Well, that doesn't make sense—unless you are trying to exaggerate numbers.

There are some small businesses in this country who have offered their employees skimpy plans. And now they are being told they have got to have minimum standards in those plans, so they are complaining a lot because they are going to have to provide decent, quality, reliable insurance. And a lot of them are helping fuel this argument.

So to say that 80 to 100 million people may lose their insurance is absolutely crazy. It is just not true. And it is especially galling to some of us when we hear Republicans so saddened by people losing their insurance when we recognize that they want a status quo which means repeal the Affordable Care Act where we had 50 million people uninsured. That didn't bother them.

So I just think that we ought to put this in perspective, Madam Secretary. This is not about this law, and it is not sincerely concern for the uninsured. It is just a political, constant political attack. The Republicans did not want to work with the Democrats, they didn't want to work with the President. If this bill has problems, let's work together to fix them, not talk about how it is no good, it is all terrible. Because I am hearing from a lot of people.

And I think the headline in The New York Times captured this. The article was titled, "Amid the Uproar Over Health Law, Voices of Quiet Optimism and Relief," they are voices like Stephanie from Lansdowne, Pennsylvania, who had a frustrating experience trying to submit her application for the first 2 months, and then after visiting a navigator at the local library, she signed up for a policy that will cost $113 a month with no deductible. And what she said is, I am one of the people whose plans were canceled and signing up this time was just the easiest thing in the world.

They are the voices of Ellen and Meredith from San Diego in 2012 they lost their coverage because they no longer lived in the plan service area. When they applied for new coverage, Ellen was denied because of carpal tunnel system. Now they have a plan through the exchange of $142 a month instead of the $1,300 a month they were paying before. They have a higher deductible than their old plan, but lower co-pays. And here is what they described their feelings, we felt we didn't have to panic or worry. If not for the Affordable Care Act, our ability to get insurance would be very limited if we could get it at all.

Madam Secretary, you have traveled around the country talk to people about this law. Do you think most people look at this as a political issue? Or are they willing to put politics aside and look at the plans being offered and make the decisions of what is best for their family?

Ms. SEBELIUS. Well, Mr. Waxman, what I find is a lot of people are eager for information. They are confused by what they read and hear. And frankly, the launch didn't help that. But as people understand their options and choices, I find that there is enormous enthusiasm, often huge relief. A lot of individuals who received the notice of cancelation are unlocked from a policy choice that they did not feel was good for them or their families. They were kind of locked into a plan. And I talk to people every day who now have 40 or 50 choices, a range of marketplace plans, the option to pick and choose.

That isn't to say that there aren't some individuals who would have preferred to stay in their plans, which is why I think the President decided on the transition policy in the marketplace. But a lot of individuals——

Mr. WAXMAN. They didn't know what they had offered to them on the exchange.

Ms. SEBELIUS. Who received cancelation notices are thrilled with the choices that are now available to them.

Mr. PITTS. Thank you, Madam Secretary. The Chair now recognizes the vice chair of the full committee, Mrs. Blackburn, for 5 minutes for questions.

Mrs. BLACKBURN. Thank you, Madam Secretary.

I want to talk to you about data security and privacy. First off, I know you have seen the USA Today story about people in California having their information released to insurance agents, and this all happened after they had gone to the exchange.

We are hearing from other States that people are having that same experience with Federal exchanges. So have you talked with the California exchange about releasing that information, help them to realize this is inappropriate to release that information?

Ms. SEBELIUS. Well, I don't think there is any question that there is an issue about releasing anybody's personal health information as was done in California. And there have been certainly conversations about that. As you know, we don't run the California exchange. That is no excuse. Privacy and security are hugely important.

Mrs. BLACKBURN. OK. How is the information being released? Who is releasing it? Who all has access to that? And when it is released, are people paying for that information? And who gets the proceeds from the sell if you are selling that information?

Ms. SEBELIUS. I am not sure. Are you talking about the California specific incident.

Mrs. BLACKBURN. I am talking about any of these exchanges where people are getting——

Ms. SEBELIUS. Well, to my knowledge, the California incident is an isolated case. We have no information—there is certainly no information about anybody at the Federal marketplace for the 36 States release——

Mrs. BLACKBURN. I think we are all getting some questions——

Ms. SEBELIUS. Well, there is no information released, and actually, we don't store personally identifiable information on the hub.

Mrs. BLACKBURN. Will you help us look into this and get to the bottom of it? Because people are getting phone calls, and that means their information is being released.

Now, if somebody is benefiting, and if that is being sold or if there is some kind of transaction on that, we need to know that, Madam Secretary.

Let's go on and talk about calls——

Ms. SEBELIUS. But I would suggest, Congresswoman, the fact that they are getting phone calls also maybe if they are customers of an insurance company who is contacting them because their policy may be up for renewal. Those calls are underway.

Mrs. BLACKBURN. I don't think that is quite the case.

But let's go on and talk about cost. $600 million is what we know has been spent on the site so far. I am referencing The Washington Post on that. How much money in total has been spent? We are still waiting for the answer to that question from you. We would like to know how much you have obligated since October 1 for the cleanup of this exchange? How much money do you anticipate obligating through March of 2014? And since you are going to have the IG do an investigation of the contracting, are you going to make these contractors pay this taxpayer money back?

Ms. SEBELIUS. Congresswoman, to date, through the end of October, and I am giving you the cleanest audited numbers that we have, we have obligated $677 million for the total IT costs, and have outlaid 319 million of that 677. Some of that includes work

clearly in the month of October, we will give you regular updates as we have newly audited numbers. I have asked the IG to become involved because I think it is very appropriate to look at all aspects of not only the management practices, but the contractor expenditures, the specs in the contract, the payment issues——

Mrs. BLACKBURN. OK.

Ms. SEBELIUS. And I will act based on his recommendation.

Mrs. BLACKBURN. OK, so 677 million is what you have obligated through the end of October.

Ms. SEBELIUS. That is correct.

Mrs. BLACKBURN. Of this year?

Ms. SEBELIUS. That is correct.

Mrs. BLACKBURN. So would you give us the additional——

Ms. SEBELIUS. Through the end of October, yes, that is the obligated amount. We have spent 319 million of that 677 through the end of October.

Mrs. BLACKBURN. We are going to continue to watch that cost number very closely.

Delays. It seems like every holiday brings another delay. So what should we expect for Christmas and New Year? We have had a total of 13 administrative delays to major aspects of the law. And it seems like whether it is July 4th or any of the holidays, Thanksgiving, we get a delay. So what are we looking at for Christmas Eve and Christmas and New Year's Eve and New Year's Day?

Ms. SEBELIUS. Well, Congresswoman, I would say that we have extended the deadline for enrollees from the middle of December until the 23rd recognizing that people need some extra time over the holidays——

Mrs. BLACKBURN. OK, into the future, what can we expect?

Ms. SEBELIUS. To choose a plan. They don't have to pay until the end of December in order to be fully enrolled, and we are working with insurers to make sure there is a smoother transition into the new year.

Mrs. BLACKBURN. Yield back.

Mr. PITTS. Thank you, Madam Secretary. I now yield to the ranking member emeritus, Mr. Dingell, 5 minutes for questions.

Mr. DINGELL. Mr. Chairman, I thank you for your courtesy and for holding this important hearing.

Madam Secretary, welcome, and thank you for being here.

As we all know, the Secretary is the famous daughter of a former member of this committee, an outstanding member from Ohio. Madam Secretary, we continue to hear nothing but scare tactics from the other side of the aisle. Rather than encouraging people to sign up for health insurance, doubt is being created where none exists or should. I am first to admit that the implementation of the law has not gone as smoothly as I would have liked, but that is, in no small part, due to the intransigence of many of my colleagues who have deliberately thrown wrenches in the gears at every opportunity.

Moreover, my constituents continue to tell me about the benefit ACA continues to bring them. And I would like to share a few letters I have received recently and I ask unanimous consent that they be put in the record.

One of my constituents wrote as follows, "I find it absurd, embarrassing and an enormous waste of time, money and human capital to see the taxes being used in Washington right now to defund the Affordable Care Act. As an individual who has a sibling with MS, a father with lung cancer and a sister with a high-risk pregnancy, I can say with absolute personal authority that the Affordable Care Act will help and is critical to the welfare of families like mine."

Another constituent wrote, "I am registered with HealthCare.gov so that I can study and compare premium prices and I am currently paying for my 60-plus employees in Ohio and Michigan. I am extremely pleased that even gold coverage plans are half of what we were paying now. There are 72 gold plans being offered. Now that is competition. So let's stop playing politics, look past the spin and realize what tremendous good ACA has already accomplished for the American people, and what more it could do if we will get together to make it as successful as it could be."

Madam Secretary, I would like to begin by asking you some a few questions about fixes to the Web site.

Madam Secretary, is it correct that the error rate on HealthCare.gov is under 1 percent, yes or no?

Ms. SEBELIUS. Yes, sir.

Mr. DINGELL. Madam Secretary, the capacity has increased to allow 50,000 concurrent users and more than 800,000 visitors daily, yes or no?

Ms. SEBELIUS. Eight hundred thousand minimum a day could come on the site.

Mr. DINGELL. Now, as the Web site has improved, we have also seen an increase in the number of enrollments through the Web site. Today we got more good news about enrollments.

My question, is it correct that 258,000 people selected a plan through both Federal and State marketplaces in November bringing the overall enrollment number to 364,000?

Ms. SEBELIUS. Yes, sir. 365,000.

Mr. DINGELL. Well, Madam Secretary, over 1.5 million people have been eligible, have been determined eligible for Medicaid, yes or no?

Ms. SEBELIUS. About 800,000 Medicaid eligibilities have been determined.

Mr. DINGELL. Thank you, Madam Secretary.

Are you confident that enrollment will continue to increase quickly in the coming weeks and months? Yes or no?

Ms. SEBELIUS. We are seeing a very positive trend, about four times as many people enrolled in the Federal marketplace in November as opposed to October, and we are seeing an upward trend in December. Yes, sir.

Mr. DINGELL. People like—Madam Secretary, people like my constituents I mentioned earlier are seeing reduced costs when purchasing insurance through the marketplace.

Is it correct that a recent Rand report found that premium tax credits will reduce out-of-pocket costs for average marketplace participants by 35 percent, yes or no?

Ms. SEBELIUS. Well, I think, sir, if people are eligible for subsidies, they will see a significant decrease over the comparable plan.

Mr. DINGELL. I am running out of time. So you have to give me yes or no.

Did the CBO project that 8 in 10 Americans who obtain coverage through the marketplace will be eligible for assistance to make their coverage more affordable, yes or no?

Ms. SEBELIUS. I think the preliminary estimates were that is what the uninsured population certainly look like, yes.

Mr. DINGELL. So ACA also benefits people who don't purchase their health insurance through the new marketplaces.

Now, Madam Secretary, is it correct that thanks to ACA, 3.1 million young Americans, adults, have been able to stay on their parents' plan, yes or no?

Ms. SEBELIUS. Yes, sir.

Mr. DINGELL. Now, Madam Secretary, 7.3 million seniors have saved over 8.9 billion on their prescription drug costs thanks to provisions in ACA that closed the Medicare part D donut hole and that that donut hole will be totally closed in the year 2020?

Ms. SEBELIUS. Yes, sir.

Mr. PITTS. The gentleman's time has expired.

Mr. DINGELL. You have been very courteous, and I thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman. I now recognize the chair emeritus of the full committee, Mr. Barton, 5 minutes for questions.

Mr. BARTON. Thank you, Mr. Chairman. Before I ask my questions, first of all, merry Christmas. And who was your father who served on the committee from Ohio?

Ms. SEBELIUS. John Gilligan from Ohio.

Mr. BARTON. John Gilligan. See, I wasn't there then.

Ms. SEBELIUS. But you may have served with my father-in-law, Keith Sebelius. So we had people on both sides.

Mr. BARTON. Just on a personal issue. Let me get to the unfun part and go to the questions.

Mr. Henry Chao of CMS, when he was here several weeks ago in response to a question of Congressman Gardner of Colorado made a statement that 40 percent of the computing system hadn't even been built yet, that all of what he called the back end hadn't been built, which I would assume would be the accounts payable and accounts receivable and income verification and things like that.

Could you tell us what is being done to try to get that ready by January the 1st since almost half the system according, to Mr. Chao, hadn't even been built yet?

Ms. SEBELIUS. Congressman, I am not exactly sure what Mr. Chao was referring to, but I can certainly tell you where we are in the build. I think the emphasis was getting the consumer facing portion ready for October 1. As you know, that didn't go so well. The financial management system which is getting the insurance companies, their money for accelerated tax credits and for cost sharing is due to go into effect in mid January. There are also some other pieces of the puzzle, not income verification. That is done as part of the application at the very front end in order to qualify someone. So that is all built in.

Mr. BARTON. Well, do you agree with Mr. Chao that a large part of this system hasn't been put together yet? And if so, aren't you concerned about that?

Ms. SEBELIUS. Well, it is in the process currently of being put together. The income issues, again, I want to clarify for the committee that, because it has been a bit of a misunderstanding, accelerated tax credits and cost sharing don't go to consumers, they go to companies. We are dealing with 2 to 300 companies. And it will, we have a system that we have announced working with companies where they will be paid in a timely fashion as this process is being built.

Mr. BARTON. I don't want to beat a dead horse. But we all agree that the Web site to try to enroll people has not worked very well, to be as polite as possible. Now that is the easy part. So now we are down to, in January, there are lots of people that think they are going to have insurance that don't have it now. And the part of the system that when they go to the doctor or to the hospital and they give them their new insurance card that they check to see if they are covered and what the coverage is, that is not there. And there is no system there to pay people. There is no system there to determine whether this doctor or this hospital is eligible, and you still want to get this thing started on January the 1st?

Ms. SEBELIUS. Congressman, I think it is not an accurate statement. We certainly have a plan, and we have vetted it and discussed it with insurers that they are very comfortable with to get them——

Mr. BARTON. They were also very comfortable that October 1st was going to work, and——

Ms. SEBELIUS. Sir, this is—people will be enrolled. That system is in place, that is what the application is about.

Mr. BARTON. After this, we will have you back here in mid January or February talking about this problem.

Ms. SEBELIUS. This is reimbursing insurance companies. At the end of the day, it has nothing to do with enrollment. And enrollment will——

Mr. BARTON. I am not saying it does have anything to do with enrollment. Let me go to my second——

Ms. SEBELIUS. When people go to the doctor and go to the hospital they will have a card. They will be——

Mr. BARTON. I have got a minute left. I have got one more question. I want to put the slide up that says on Section 1401. Under the law, Section 1401 says that if you go through a State exchange to get insurance under what we call Obamacare, that you are eligible for a subsidy. If you don't go through that State exchange, you are not eligible for a subsidy. Now, IRS has ruled that we don't have to obey the law. We are going to give the subsidies if we go through the State exchanges or not. What is HHS's position on obeying the law, and doing what the law says, which would mean almost everybody who signs up for Obamacare is not eligible for a subsidy because they are not going through the State exchanges?

Ms. SEBELIUS. Sir, we have deferred to our partners at the Justice Department, and at the Treasury for——

Mr. BARTON. Now, what is your position? What is the HHS's position?

Ms. SEBELIUS. We have referred to our partners. This is in litigation, as you know, right now.

Mr. BARTON. I am asking what your position is? You are not worried about obeying the law?

Ms. SEBELIUS. We feel that the law covers both State and Federal exchanges.

Mr. BARTON. That is not what it says.

Ms. SEBELIUS. The recommendation of the Justice Department——

Mr. PITTS. The Chair thanks the gentleman. Thank you, Madam Secretary. I recognize the gentleman from Utah, Mr. Matheson, 5 minutes for questions.

Mr. MATHESON. Well, thank you, Mr. Chairman, and Madam Secretary, thanks for joining us today.

You know, we have already had one hearing on the Web site before now. We are all aware of some of the challenges of the rollout. You know, when you come before a committee there is all kinds of things—other topics I would like to raise with you, issues about the health insurance tax, or difficulties some providers are having with meaningful use, Stage 2, but in the—I think this hearing is more about rollout of Web site itself, and so I will focus on that in my questions today.

I think we all know that, and you have acknowledged the criticism of the Web site when it was coming out. Let me ask you a question. As we go forward, have you developed sort of a master list of the issues that still need to be resolved, or the issues you are trying to anticipate as we move forward from today?

Ms. SEBELIUS. We are doing that on an updated basis, yes, sir, both on a policy side and on a technology, and user side.

Mr. MATHESON. So that is not a static list. That is an evolving list. As time goes on you see other things?

Ms. SEBELIUS. Yes, sir.

Mr. MATHESON. OK, is it possible for that list to be shared with the committee or is that something that we could see on this committee, or——

Ms. SEBELIUS. As you say, it is not a static list.

Mr. MATHESON. Right.

Ms. SEBELIUS. It is a dynamic list, and it is basically anticipating what the next policy changes are, what happens. You know, we are happy to give the committee an outline, but I don't think there is any great secret to it.

Mr. MATHESON. OK. OK. You know, I wanted to talk about some of the issues that—addressed with the 834 form, or I know the error rate has been dropping and enrollment is increasing at the same time, so you kind of have these lines going in opposite directions, both favorable directions. But that being said, do you have a sense of how many enrollees may have 834 errors that need to be addressed?

Ms. SEBELIUS. What I can tell you, Congressman, is we know in the early days, there were a serious number of error, and we are in the process of actually hand-matching individuals with insurance companies. They have added some important personnel to the tech team so that they are helping to identify where the bottle-

necks were and fixes. We are seeing a vastly improved system, but we want to go back and make sure——

Mr. MATHESON. Right.

Ms. SEBELIUS [continuing]. That everyone who thinks they are enrolled in the early days is actually matched with a company, and that the company folks are matched on our end, and that process is very much underway, and a lot of fixes have been——

Mr. MATHESON. Right.

Ms. SEBELIUS [continuing]. Added in October or November for the 834s.

Mr. MATHESON. And in terms of that declining error rate, how do you calculate that? Is that an average of all of the plans or is that a snapshot of the subset as you go forward? How do you go about figuring that out?

Ms. SEBELIUS. Well, it isn't really plans. It is looking at the site and determining the errors that occur along the way, so pages that came up, or people got locked out or dumped out, or wouldn't accept an ID, and that has really been the roadmap to what really needed to be fixed and that has been a very dynamic process that is still underway.

Mr. MATHESON. Right. And following up a little bit on what Mr. Barton was asking you about some of the issues more on the back end, you know, I guess CBO has predicted about 6 million individuals are potentially going to seek subsidies, and for folks, not everyone is going to start up January 1. I understand the open enrollment period goes beyond then. But as these first month's premiums for the folks starting January 1 are coming up, is there—are we going to have this system in place, where these subsidies and these payments at the back? Is the back-end system going to be structured in a way where the subsidy payments are going to be able to be made for this first month of participation?

Ms. SEBELIUS. Yes, sir. They will be made and they will be made in a timely fashion, and they are made in a way that the insurers have agreed that works for them. So as the full system is being automated, there is a step in the early months to make sure that the payment to insurers, again, an individual will be enrolled, qualified for a subsidy. The insurer will accept a premium. At that point, that individual is insured, and has full benefits. Starting in mid-January, the insurance companies then receive reimbursement for the tax credit and cost sharing, if it is eligible for individuals, so it is a two-step process.

Mr. MATHESON. Right.

Ms. SEBELIUS. One affects the individual. The second affects the companies, 2- to 300 companies total. We have a system that, again, has been signed off by them in terms of getting them paid in a timely fashion and we will absolutely do that.

Mr. MATHESON. And the subsidies go directly to the insurance companies?

Ms. SEBELIUS. Yes, sir, not to the individual.

Mr. MATHESON. OK. And so when we hear about these problems about needing to build up the back end, you are saying that this particular component you have got——

Ms. SEBELIUS. Well, there is a manual workaround, I would say, for virtually everything that isn't fully automated yet. It is in place.

It just will be manual until the automation is fully complete and we have tested it and made sure it works. But in the meantime, the payment system will absolutely go forward.

Mr. MATHESON. OK. Thank you. I yield back, Mr. Chairman, thank you.

Mr. PITTS. The Chair thanks the gentleman. I now recognize the vice chairman of the subcommittee, Dr. Burgess, 5 minutes for questions.

Mr. BURGESS. Thank you, Mr. Chairman, and Secretary, welcome back to committee. I may not have an opportunity to go through all of the things on the list. We have submitted questions for the record in the past. We have not received answers to those. So let me, again, encourage you to respond to previous questions and to these question, because they are important and constituents are asking us, in fact, constituents on a telephone town hall earlier this week, single mother, earns just over the amount so good for her. She has got a good job; works for a small employer; lost their insurance in the small group market.

Now she is being hit with a premium, an unsubsidized premium for which she is not eligible for a subsidy of $1,500 a month for her and her child. I mean, when you were working through the nuts and bolts of establishing this law, did that situation come to mind? Were you concerned at all about that individual?

Ms. SEBELIUS. I am concerned about all individuals having affordable health coverage, yes, sir.

Mr. BURGESS. Well, apparently she doesn't have affordable health coverage. In her opinion, she lost her employer small group market coverage.

Ms. SEBELIUS. The employer chose to drop the coverage then.

Mr. BURGESS. Because of the expense involved with that. OK, you were here in April. I think it was April 18th. You had just received 2 weeks prior a Red Team discussion document from McKinsey Group. My information is that you were briefed on this report 2 weeks prior. That is what is listed on the final page of the report. Let me just play a little clip of our interaction from April.

OK, that is going to take too long. Let me just tell you what we are dealing with. The study that the McKinsey Corp—Group put together dealt with the readiness of HealthCare.gov. I was asking you about the readiness, and you replied that we are moving ahead. We have a Federal hub on track and on time. Do you recall that exchange between the two of us?

Ms. SEBELIUS. I am sure that exchange took place, sir.

Mr. BURGESS. But here is the question. Two weeks before you were told by the McKinsey Corporation or the McKinsey Group, that number one, they weren't allowed—they found extensive problems. They weren't allowed to change the launch date. The thing had to launch at full volume, and that no one was in charge. The completed project was a moving target. So you were aware of all of that when you came and testified before the committee in April, were you not?

Ms. SEBELIUS. Sir, I asked for the McKinsey Group to come in 6 months ahead of launch date and give us an analysis of their best advice. I was briefed on it and we acted on their recommendations.

Mr. BURGESS. You were the one who commissioned the McKinsey Group report?

Ms. SEBELIUS. Pardon me.

Mr. BURGESS. You were the one who commissioned the McKinsey Group?

Ms. SEBELIUS. We asked for them to come in, yes.

Mr. BURGESS. You yourself?

Ms. SEBELIUS. Yes, sir.

Mr. BURGESS. Well, again, I just have to ask you, what did you do with that information because you weren't being honest with us 2 weeks later when we were talking about it in committee.

Ms. SEBELIUS. Sir, I would disagree. We wanted the report 6 months out to make sure that we had independent eyes and ears look at the readiness, look at the challenges, and we took their advice very seriously. I would tell you, sir, that their primary advice focused on the reliability of the hub. They thought that would be where the large number of problems occurred. We focused a lot of time and attention. We looked at——

Mr. BURGESS. And may I submit that they were actually accurate in that assignment.

Ms. SEBELIUS. The hub has worked beautifully from start to finish.

Mr. BURGESS. Look, you have testified this morning that there is—people cannot actually make their payment now when they go on HealthCare.gov.

Ms. SEBELIUS. No, that is not accurate, sir. I said a lot of people haven't yet made their payment. Their payment isn't due.

Mr. BURGESS. I was unable to make my payment on HealthCare.gov on the Federal exchange from the State of Texas, and I was told you can't make that payment. I have not——

Ms. SEBELIUS. When you are an insurance company you don't pay the Federal Government. We are the sign-up site and you make the payments directly to the insured.

Mr. BURGESS. OK, December 23rd, you said if someone has worked through the process, they are going to be covered. But payment may not have been made, is that correct?

Ms. SEBELIUS. What I said, sir, is that you have to be enrolled by the 23rd, and make a payment by the end of the year in order to be fully insured. And the insurance——

Mr. BURGESS. Who is going to guarantee that the doctor that sees that patient on January 4th is actually covered for that visit? Are you going to make——

Ms. SEBELIUS. Same as they do today. You are enrolling in a private insurance plan. You have to pay your premium in order to——

Mr. BURGESS. What if that patient doesn't make the premium payment? You said they are covered December 23rd, but they never write the check. They never make the payment.

Ms. SEBELIUS. Then they are not covered.

Mr. BURGESS. But they think they are covered.

Ms. SEBELIUS. They are not enrolled. And at every point along the way on the Web site, they are told they until they make the payment——

Mr. BURGESS. Well, are you going to make good for those doctors who see those patients the first couple weeks of January who then

have their cash flow interrupted? I will just tell you, for practicing, in a small practice, you get your cash flow interrupted for 2 or 3 weeks, that is big trouble.

Ms. SEBELIUS. Well, again, if an insurance company gives an enrollment to a customer, they will make good with the provider. We tell people over and over again, they are enrolled when they make a payment. We turn their name over to the insurance company.

Mr. BURGESS. But you said earlier this morning——

Ms. SEBELIUS. And that insurance company deals with their new customer.

Mr. BURGESS [continuing]. If they are enrolled by the 23rd, they are not going to be covered.

Ms. SEBELIUS. Sir, not until they pay, and that is what every step along the way.

Mr. BURGESS. Do you know how hard it is to actually make that payment, pull the billfold out and actually make the payment? Have you done that yourself?

Ms. SEBELIUS. I have not.

Mr. BURGESS. Well, I am going to tell you, it is almost impossible. I have never seen a business where you get to the point, the fundamental business transaction, you are going to make the payment, and you can't do it.

Mr. PITTS. The gentleman's time is expired. Thank you, Madam Secretary. The Chair recognizes the gentleman from Georgia, Mr. Barrow, 5 minutes for questions.

Mr. BARROW. Thank you, Mr. Chairman, and thank you, Madam Secretary, for being with us today. I am glad there has been some progress since the last time we met, but I am still concerned what is going to happen when the insurance that is mandated under that goes live at the first of the year. I voted against the health care bill, in large part, because I thought the whole thing was just unmanageably big to begin with, and I am worried that we have only seen the tip of the iceberg. I hope I am wrong about that.

I want to ask you about other approaches toward the fundamental chore of trying to get folks enrolled in plans required under the Act. Are there other—are there other insurance plans out there that are Internet-based? Aren't there other folks who are selling health insurance on Internet-based exchanges?

Ms. SEBELIUS. I think some of the companies haveInternet sites, and I know that the Esurance, eHealth brokers have a variety of plans available. I can't tell you how broad based that is, but I know a number of companies you can either sign up in person with an agent or broker, or sign up online.

Mr. BARROW. To what extent were efforts made to reach out to such folks to try and learn from what they are doing, or to try and utilize the technology that they are already utilizing to sell health insurance on the Internet?

Ms. SEBELIUS. Well, I think there was a lot of outreach, and a lot of conversation about what works and what doesn't. I would suggest that this is a unique, integrated product because not only is an individual identified and verified, but can qualify then for a tax credit and cost-sharing based on his or her income, can be qualified for not only the Federal marketplace, but Medicaid CHIP services, and in the Federal Web site, each plan, each State offers

a different number of plans, each State has a different set of Medicaid rules, and each State has a different level of benefits.

So it is basically an integrated system that tries to get you to the right place so you can make a choice.

Mr. BARROW. Well, are private health insurance plans that are operating on their own Internet-based health exchanges, actually able to take advantage of the unique features of the law, the fact that you get subsidies if you are income eligible, the fact that there are specific packages that are required——

Ms. SEBELIUS. Not unless they verified that information through the hub. No one can have——

Mr. BARROW. Is that being done? Can it be——

Ms. SEBELIUS. Yes, sir.

Mr. BARROW. It is being done?

Ms. SEBELIUS. It is.

Mr. BARROW. Through private insurance companies?

Ms. SEBELIUS. Yes, sir.

Mr. BARROW. Who?

Ms. SEBELIUS. They don't have direct access to the hub. They come into the hub through CMS——

Mr. BARROW. I understand that. I understand the aspects.

Ms. SEBELIUS. Well, Blue Cross Blue Shield and Web plans are doing this direct enrollment all over the country now that the site is functioning.

Mr. BARROW. Well, the reason I ask is, if there are other sites, other Internet-based exchanges already functioning, it seems to me that it would be a very helpful approach to have all hands on deck in trying to do that.

Ms. SEBELIUS. Well, I am sorry. To clarify, they are. The eHealth insurance folks are now engaged and involved. The broker is involved in that. The companies are directly involved as well as individuals navigating on their own.

Mr. BARROW. Are you telling us that folks who would otherwise be able to get health insurance through HealthCare.gov can get their insurance through a private Internet-based exchange such as eHealthinsurance.com?

Ms. SEBELIUS. Well, it again, has to—if they are subsidy eligible, they need to touch the hub and get that verified so that that subsidy goes forward with——

Mr. BARROW. Who is the "they" that need to do that? The insurance companies you are dealing with or the customer?

Ms. SEBELIUS. Well, sitting in the office with a broker; they can do it with the eHealth insurance folks; they can do it on their own; they can do it with a navigator. They can do it on the call center. So there are a whole variety of ways that individuals can do that. If they are not subsidy eligible, if they make more than $46,000 as an individual or about $92,000 as a family, they can just go directly enroll in a marketplace plan with their——

Mr. BARROW. I recognize that, but again, back to the point you began with, the role that HealthCare.gov is supposed to provide is to try and match folks up with the subsidies as well as the products that are out there and you are saying that can be done through private exchanges that exist right now. It doesn't have to be done through HealthCare.gov.

Ms. SEBELIUS. Again, they—the subsidy eligibility which involves verification of income, verification of citizenship, verification that you are who you say you are——

Mr. BARROW. Right.

Ms. SEBELIUS [continuing]. Has to touch HealthCare.gov. Other than that, the enrollment process can be done in any——

Mr. BARROW. That touching, that front door that is provided by a private Internet-based exchange communicates with folks in the back room at the government, on the government end, is that correct?

Ms. SEBELIUS. Well, again, they do not have access to the Social Security database, to the IRS database, to the Homeland Security database, that is the piece that verifies the individual's eligibility, and can move them forward, but that is being done now by agents and brokers, by the eHealth folk, by a variety of people along the way.

Mr. BARROW. Thank you, Mr. Chairman.

Mr. PITTS. The gentleman yields back his time. Thank you, Madam Secretary. The Chair now recognizes the gentleman from Kentucky, Mr. Whitfield, for 5 minutes for questions. I would like to ask the gentleman from Pennsylvania, Dr. Murphy, to take the chair.

Mr. WHITFIELD. Well, thank you, Mr. Chairman, and Madam Secretary, thank you for being with us. Mr. Waxman admonished us to treat you with respect, and I think that certainly, we should do that, and we want to do that. But I will tell you, my very first concern is with the constituents that we represent. And some people have said that we are simply trying to put obstacles up for the successful implementation of this Act. And I can tell you for myself and many others, we are here because our constituents are genuinely concerned and upset about what is going on. And a lot of it begins with the way this bill was passed.

When it came to the floor, the most comprehensive change for health care in America that has ever been undertaken, no one could offer one amendment to the bill. And I would—so there are very deep feelings about this still, and many health care experts today say that we are going quickly to a two-health care system. We are going to have one health care system for wealthy Americans, and then everyone else is going to be under the Affordable Care Act.

And that is exactly what has happened in other countries that have gone down this path. Now, when this legislation passed, your office was given immense powers and decisionmaking authority, and we know that many regulations have been written.

Could you tell me how many pages of regulations have been written to implement this Act?

Ms. SEBELIUS. Sir, I can get you that number. I do not know.

Mr. WHITFIELD. Do you have any idea?

Ms. SEBELIUS. I don't know how many pages.

Mr. WHITFIELD. Do you have a range?

Ms. SEBELIUS. I would like to get you accurate information.

Mr. WHITFIELD. I mean, is it 100 pages, or——

Ms. SEBELIUS. Sir, I will get you information.

Mr. WHITFIELD. So you don't know.

Ms. SEBELIUS. I just told you, I don't know.

Mr. WHITFIELD. OK. Now, the President went all over the country talking about how this is going to save money, people are going to have lower premiums. And I can tell you, those of us on the Hill who have been going on the DC health exchange, have discovered that our premiums are certainly much higher than they were, and when we talked to our constituents going on the exchanges, we are discovering that the majority of them, their premiums are much higher. And my understanding, OMB has said that the subsidy will cost the taxpayers over $1 trillion. We have been told that—I am sorry?

Ms. SCHAKOWSKY. Will save.

Mr. WHITFIELD. Will save? Well, the subsidy will cost the taxpayers $1 trillion. Somebody has got to pay for it. And I would also like to ask you a question because of what is perceived as a real inequity in this system, how some people are being favored, other people are not being favored.

When you go to the rotary club and speak, and people ask you, do you have to go on to the exchange? Does the President have to go into the exchange? Do the political appointees have to go onto the exchange? And you say no, does that—do you think that is fair that the rest of the American people have to go under this exchange, but you and the people in the President's—in the executive branch of the government do not have to go on the exchange?

Ms. SEBELIUS. Well, sir, I would tell you that the vast majority of Americans with insurance also will not be on the exchange; 177 million people have——

Mr. WHITFIELD. But I am asking about you.

Ms. SEBELIUS [continuing]. Employer-based coverage. It is, as I said to this committee, in October, illegal for me to go on to the exchange. I misspoke slightly because the reason it is illegal for me, which I knew, is I am an old lady. I am Medicare eligible. It is illegal for a company to sell me a policy because——

Mr. WHITFIELD. You don't have to go under Medicare, though.

Ms. SEBELIUS. I am not allowed to be sold a policy in the private market, if you are over 65, and I am.

Mr. WHITFIELD. Thank you for your comments, but the bottom line is the executive branch of government does not have to go on the exchange. Everyone else does have to go on the exchange.

Now, in addition to the $1 trillion that the taxpayer is going to pick up on the subsidy, they are going to pick up another $710 billion because the President agreed that the Federal Government would pay more of the State Medicaid cost.

Ms. SEBELIUS. Sir, that is fully paid for in the health care law, and in fact, CBO has estimated that it reduces the deficit——

Mr. WHITFIELD. It is fully paid for by the taxpayer dollars, by general fund dollars.

Ms. SEBELIUS. Unlike Medicare Part D this actually, this bill was paid for——

Mr. WHITFIELD. And then let me just tell you this. The President said that everyone's premiums would be free. The President said that people would be able to keep their plan. The President said they would be able to keep their doctor. It is turning out that that

is simply not the case, and so there is a lot of frustration, and we are upset about it, and my time is expired. So thank you.

Mr. MURPHY [presiding]. Thank you. The gentleman's time is expired. Ms. Schakowsky, you are recognized next for 5 minutes.

Ms. SCHAKOWSKY. Let me clarify some things using the Dingell yes-or-no strategy. Is it not true that the Congressional Budget Office said that 8 out of 10 Americans who will go to the marketplace, will qualify, should qualify for assistance?

Ms. SEBELIUS. I think that is true.

Ms. SCHAKOWSKY. And yes or no, is the Affordable Care Act paid for? I know you referred to that, but if you could explain that.

Ms. SEBELIUS. It is paid for, and in fact, again, the Congressional Budget Office estimates that it will reduce the deficit in the first 10 years by about $120 billion and then over the next 10 years, reduce it closer to $1 trillion. So defunding, or delaying, or repealing the Affordable Care Act actually adds to the deficit.

Ms. SCHAKOWSKY. And isn't it true that many of the people that have gotten these letters about the cancellations will be able to go to the marketplace and find something better, or at least as good?

Ms. SEBELIUS. Well, again, in the individual insurance market, which is what we are talking about, the plans change on a very rapid basis, are constantly refreshed. So having a plan cease to exist is not a novel idea. There are a significant percentage of people who will be grandfathered in, have the same plan they had in March. They don't change at all.

For others, they will have choices, many of them that they never had before, both to get some assistance, financial assistance if they don't have affordable coverage in their workplace, get some financial assistance paying for health coverage, but also be able to choose in a competitive marketplace and not be locked out because of a preexisting condition; not pay 50 percent more because they are a woman; not be worried about being dropped or kicked out if they get sick down the road.

Ms. SCHAKOWSKY. You know, we have been going by anecdote, and so I wanted to just read you a letter that I got. I am going to contribute to the anecdote pile from Jeanine and Jeff. It says: "Since so much of the Affordable Care Act debate has focussed on anecdotes instead of the many benefits, such as not denying coverage for preexisting conditions, and coverage for young adults under 26, we thought we would share with you our positive experience with the Web site. Like many American families, our young adult children asked for help reviewing the options and making the health insurance decisions while they were visiting us over Thanksgiving weekend. We went to HealthCare.gov and it worked. Not only did the Web site work, but it was easier to navigate and faster than the Web sites of the private-sector health insurance companies. The other good news is that our daughter, Erica, is pregnant with a baby due in March of 2014. Her current health insurance policy is expiring on December 31st, and were it not for the Affordable Care Act, it is unlikely that a woman who is 6 months pregnant would have been able to obtain health insurance at all. The ACA is helping her just when she needs it the most."

I have two others that I would actually like to submit for the record, positive stories that I am getting.

[The information follows:]

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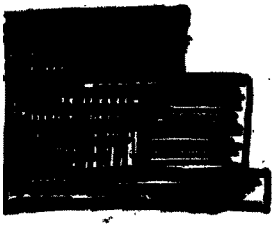
[redacted]

Dear Jan,
Since so much of the Affordable Care Act debate has focused on anecdotes, instead of the many benefits such as not denying coverage for preexisting conditions, unlimited coverage and coverage for young adults under 26, we thought we would share with you our positive experience with the web site. Like many American families, our young adult children asked for help reviewing the options and making health insurance decisions while they were visiting us over the Thanksgiving weekend. We went on Healthcare.gov and it worked! Not only did the web site work well, but it was easier to navigate (and faster) than the web sites of the private sector health insurance companies.
The other good news is that our daughter Erica is pregnant and the baby is due in March of 2014. Her current health insurance policy is expiring on December 31, 2013 and were it not for the Affordable Car Act it is unlikely that a woman who is six months pregnant would have been able to obtain health insurance at all. The ACA is helping her just when she needs it the most.
Best wishes,
Janine and Jeff

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<MSG>
Thank You!
I'm tired of all this bellyaching about health care, so I want to share our story. We are small business owners and have a very expensive policy for our two employees but we have been stuck with that approach because my husband and one of our kids have asthma and are therefore un-insurable. Our health care broker just sent us all the health care info for next year - first, our current small business policy premiums are 4% lower. This is a first and it certainly at least partially a result of the new competition. Our broker did an analysis for us and our yearly costs will go down even more if we switch to one of the Obamacare options in Illinois.
Although we do not qualify for subsidies, it is cheaper in all scenarios. In fact, if our usage is similar to what it has been the past 3 years our costs go down 20%. The policy is better, everyone in the family is now insurable, my kids who are still under 21 may be able to get dental insurance (wouldn't that have been nice the past 5 years?); and the out of pocket maximum is lower if someone gets really sick. Wow.

These savings don't include the benefit of being able to keep our un-insurable 22 year old on our policy the last year or so, and the no deductible checkups and preventative drug benefits - which have already saved us over $1800 this year. Our healthcare broker and his partner are signing up for Obamacare options themselves, so I know we aren't the only ones. Yes, its complicated, but it was anyway.
I say thank you to all those made it happen. And I'd like to know what all those Republican Grandstanders who have blocked action at every turn and are now wringing their imaginary hands have done for me lately?

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Ms. SCHAKOWSKY. We are getting more and more of those stories, and I just want to say to you, Madam Secretary, I am absolutely confident that the role that you played in bringing affordable health care to millions, tens of millions of Americans, will go down in history as one of the great achievements of our country throughout its entire history. And I just want to thank you for that. I understand and fully agree that the rollout was, you know, is unpleasant, and as horrible as it could have been, probably, but by the new year, and into the new year, we are going to find all of these stories.

My understanding is that 39 million people went to the—either State or Federal Web sites during November. Is that true?

Ms. SEBELIUS. I think that is accurate. We know we had, at least at the Federal Web site, 5 million visitors in the first 6 days of December.

Ms. SCHAKOWSKY. And what do you think that indicates?

Ms. SEBELIUS. Well, as we have seen all along there is tremendous interest. There is now a very updated and easy-to-use anonymous shopper that will give people information before they go on and enroll, and what we are seeing is people coming back several times. This is an important decision. It is important for them and their families. And visiting the site, they are eager for information, and they are desperate, many people, for affordable health coverage that they have never had before in their lives.

Ms. SCHAKOWSKY. Thank you. I yield back.

Mr. MURPHY. The gentlewoman's time is expired. I now recognize the gentleman from Illinois, Mr. Shimkus, for 5 minutes.

Mr. SHIMKUS. Thank you, Chairman. Thank you, Madam Secretary. I am going to try to be nice, and polite, and kind. And it is difficult because we are frustrated because we really want to get some of the truth out. Last Congress, you testified, and to me, and to this committee, that we actually, we double counted the $500 billion; $500 billion was counted to preserve Medicare; $500 billion went to—was credited to pay for Obamacare. You admitted that. So you can't tell us that this is paid for when we double counted $500 billion. I just want to put that on the record. And as for the amounts of enrolled, in Illinois 1,300 have enrolled in a plan, 1,300. Twenty times more have enrolled in Medicaid. And this Medicaid explosion, either—that are enrolled fraudulently, or enrolled through woodworking, or enrolled through the new expansion are going to kill the States.

Madam Secretary, when Amazon.com records a book sold, they record a book sold by based upon someone who has paid for it, not what is in their shopping cart, and not what is on their wish list. So our concern is this 364,000 number is fraudulent, because it is not those who have purchased plans yet. And so I would ask that when you return, that you give us actually who has purchased plans. Do you understand our frustration with that?

Ms. SEBELIUS. Sir, as you well know, we did not take over the private insurance market. People will purchase plans.

Mr. SHIMKUS. But you are telling us that those who—just shop are enrolled.

Ms. SEBELIUS. I told you, sir, who is enrolled.

Mr. SHIMKUS. OK, that is why we are frustrated, because we just don't get the truth out of you.

Ms. SEBELIUS. This isn't Medicare, and we don't have to enroll in a government plan.

Mr. SHIMKUS. Let me go to my next question. Let me go to the next question. I had my phone on, and when my phone rang, I left it on because I wanted to talk to a Democrat State Senator from my State of Illinois, who is on the insurance commission. And he said, and I quote, "Mandated preventive services are laid directly on premium prices." Now, so it is—you cannot say, as you had numerous times, that these preventative care services are "free of charge," can you?

Ms. SEBELIUS. They are free to the consumer, yes, sir.

Mr. SHIMKUS. There is no free lunch, Madam Secretary. If the premium is increased because of the mandated coverage based upon a State Senator from the State of Illinois, a Democrat, who is in oversight of the insurance of the State of Illinois, and he says, when you mandate coverage, it is rolled directly on premiums. As premiums increase, that is paying for these services. You cannot say that these are free of charge.

Ms. SEBELIUS. Again, consumers will not have a copay or deductible. And I think that——

Mr. SHIMKUS. Will you admit they will have a higher premium?

Ms. SEBELIUS. Sir, no, I do not. I think what a lot of actuaries——

Mr. SHIMKUS. OK, all right.

Ms. SEBELIUS [continuing]. Will tell you is if you have preventive care, and prevent a more costly hospital stay, cancer episode, down the line, that actually lowers the premium. It doesn't raise it.

Mr. SHIMKUS. All right, I got it. We are just going to agree to disagree. It is like talking to the Republic of Korea or something. Last question.

Ms. SCHAKOWSKY. Mr. Chairman, you have to let——

Mr. PALLONE. Mr. Chairman, you have to let—we said in the beginning——

Mr. SHIMKUS. I do not have to——

Mr. PALLONE. We said we were going to let the Secretary answer the question.

Mr. SHIMKUS. The gentleman controls the time. If the Democrats want to yield some time——

Mr. PALLONE. I know, but you have to leave her the opportunity to answer the question.

Mr. SHIMKUS. I do not have to allow her——

Mr. PALLONE. Yes, you do. We all agreed on that at the beginning. You have to allow the Secretary answer the question.

Mr. MURPHY. The gentleman will suspend. The gentleman will suspend. Give the Secretary time to answer questions.

Mr. SHIMKUS. Last question. Madam Secretary. Through the great work of Congressman Chris Smith, we know that of 112 plans offered to congressional employees, and Members, only nine offer—nine policies exclude abortion coverage, and I have his flier that he handed out to us.

Madam Secretary, you promised last time you were here, that you would provide me a National list of those who cover and those

who do not cover abortion and abortion services. We have yet to receive that list. Now, folks are shopping now, and I will tell you, when we went through this last time, we received a call from my office, from someone in the country, who was pro-abortion thanking me for that question, because they want to know. We need that list, Madam Secretary, and if they are shopping today, we need that list today. When will you provide that?

Ms. SEBELIUS. Sir, every plan lists planned benefits and the one plan benefit that they must list by law is abortion services. So as a shopper goes on, I would highly recommend that they look in the plan benefit section. Check for the coverage they are interested in.

Mr. SHIMKUS. OK, the last time I was here I held up numerous policies that were not explaining that. In essence, you promised to provide the list of those insurance plans. All we are asking is for you to keep your promise.

Ms. SEBELIUS. It is the summary of benefits and plans. I guess we could go on——

Mr. SHIMKUS. Will you provide us a list?

Ms. SEBELIUS. I will ask the——

Mr. SHIMKUS. You promised the last time.

Ms. SEBELIUS. Sir, it is on the Web site.

Mr. SHIMKUS. Will you promise—if it is on the Web site, can you provide it?

Ms. SEBELIUS. It is available.

VOICE. Regular order.

Mr. MURPHY. Madam Secretary, were you going to answer the gentleman's previous question?

Ms. SEBELIUS. Pardon?

Mr. MURPHY. Were you able to completely answer the question that the gentleman asked prior?

Ms. SEBELIUS. I assume so.

Mr. MURPHY. OK, thank you. Mr. Green of Texas is recognized for 5 minutes.

Mr. GREEN. Thank you, Mr. Chairman. Madam Secretary, thank you for being here and taking time to testifying. First of all, let me give a little history lesson. And I know my colleagues are upset that this bill was passed at night, the Affordable Care Act in 2010. I was here in 2003, and the prescription drug plan did also not allow amendments on the floor of the House, and I remember walking out of the front of the Capitol and seeing the sun rise from the east that morning on a prescription drug plan. So we were there all night. So you can dislike the law, but you can't say because it was passed at night or that there were no amendments on the floor, you did the same thing as the majority and that is not uncommon for comprehensive bills that we have on the floor.

Mr. BURGESS. Will the gentleman yield?

Mr. GREEN. No, I won't yield. I only have 5 minutes. The other issue is, the reason that the administration is not covered on the exchanges, any employer, or employee who has employer-based insurance, doesn't need to go to the exchanges. Now, Members of Congress are the exception of our own doing. It was part of the bill that came from the Senate. And believe me, I disagree with a lot of the things that the Senate put in that bill, and I know my rank-

ing member and I both have some issues with the way the law is now and we would like to change it.

But the House bill, we had hours and hours of amendments in this committee. I had 30 amendments on my own, and a number of them were bipartisan that were adopted by voice vote. So our committee had plenty of time to debate this bill. We did that to prescription drug plan, too, because I was here in 2003. We had a lot of committee amendments, but not out on the floor, and we didn't have one on the floor either. But let me get to my questions.

First of all, since the launch of the exchange on October 1st and problems with HealthCare.gov Web site are glaring and unacceptable, and I know you took responsibility for it along with the President. I am pleased that we have seen a great deal of progress made since then, and I hope that we continue to see success in the area, and that the Affordable Care Act can deliver on its promise to make coverage available and affordable to Americans who are stuck with unfair and unstable individual market health care, the insurance market. But that market is still available even though in a lot of cases that is why the Affordable Care Act was needed. It was broken. What fixes are still need to be made to make the experience of purchasing health care on HealthCare.gov easier for consumers?

Is this an onward process that you are learning every day, I hope? Because in business, we learned every day that fix—serve our customers.

Ms. SEBELIUS. We are definitely learning every day, Congressman, and I would say since I was here last, the greatly improved anonymous shopper feature is on. We just added today, the automated Medicaid transfers recognizing that some States are not able to accept them in an automated fashion, so we will do both. We have added Cuidado de Salud which is the Spanish version of the Web site experience that rolled out last week.

We are in the process, as I said, of building the financial management, but each and every day we learn something from consumer experience. It is a process where each week we are adding fixes, identifying problems, and will continue to do that. This is a first-of-a-kind product, and we are going to continue to make the experience more smooth for consumers.

Mr. GREEN. Well, and it is important for the Web site to work. Because in the middle of November we had an event in Houston where we had 800 people show up on a Saturday morning, and we used paper applications. That is my next question. The 400 or so people who filled out those paper applications in that 4 hours on a Saturday morning, how are they being dealt with through the exchanges?

Ms. SEBELIUS. Well, sir, we have a number of people who used paper applications early on or PDF applications, and we are recontacting each and every one of those people, offering them either somebody to help them walk through the Web experience, or inviting them to do it themselves so that is very much underway on a casework basis. We want to make sure that anybody who filled out a paper app is actually welcomed in the system and gets through the process by the 23rd if they want coverage January 1st.

Mr. GREEN. Well, I think it is interesting though, because my colleagues objected to the marketplace. But you know, the marketplace was actually a compromise in the Senate. You know, the House bill that passed did not—we had an exchange, but it was separate because we also a public option on that exchange. So it is only market-based. And when I went on to buy our insurance, and I agree with my colleagues, my insurance has gone up. Like you, I am over 65. And you rate wife and I, we are going to pay higher premiums. We did have trouble even through the one for the Members of Congress. But most of the people in our country are not going to deal with the exchange because if their employer continues to provide their coverage, they don't have to worry about this. And I can also say that I have had dozens and dozens of seniors because of all of the misinformation out there, who are confused, who have Medicare. And say, I am concerned about my Medicare. Well, Medicare has only been benefited by the Affordable Care Act. And again, thank you for your time.

Mr. MURPHY. The gentleman's time is expired. I now recognize myself for 5 minutes. First of all, Madam Secretary, thank you for being here, and I also want to thank you for getting the mental health parity regulations done. Those are very important and you put a lot of work into it. Thank you. And there is more work we all have to do on mental health issues, and I would welcome an opportunity to meet with a number of us to talk about some of the things we need to do to help mental health in America. And I appreciate your dedication to this. I also want to thank you for this analysis. It is helpful for us to really see some breakdowns of what is taking place with regard to the States and the marketplace. I want to ask some clarifying questions to see if you know or if you can find out on this.

Of those who have signed up, you have a list of those who signed up for Medicaid and CHIP marketplace. Do we know how many were previously eligible for Medicaid? Not those that were added on who were previously eligible. Do we know that number?

Ms. SEBELIUS. Sir, I don't know those numbers and we are trying to get those numbers at the State level. Again, we know that a lot of people even in non-expansion States have come forward and now are presenting themselves as Medicaid eligible. But how—what is the old rules and what are the new rules, we are getting that number from the States.

Mr. MURPHY. Will you be able to find out that amount? So we had the previous level and now it is up to 133 percent of income or whatever it is in various States. It would be nice to know how many were previously eligible and just never signed up.

Ms. SEBELIUS. Right.

Mr. MURPHY. And how many are newly eligible and signed up. Thank you, if you can get us that information.

Ms. SEBELIUS. Yes.

Mr. MURPHY. Also, in terms of the analysis of the data which is very important, of those who have——

Ms. SEBELIUS. Sir, and I am sorry, can I interrupt one second?

Mr. MURPHY. Yes.

Ms. SEBELIUS. There is actually a third category. We know that there are people who are currently enrolled in Medicaid who are sort of reenrolling.

Mr. MURPHY. Yes. Yes.

Ms. SEBELIUS. So they are not new to either category, but they actually are renewing.

Mr. MURPHY. Precisely, yes. We would like to know that.

Ms. SEBELIUS. And they are part of that, to look at that three-way breakdown.

Mr. MURPHY. The renews previously eligible but didn't sign up and newly eligible. Thank you.

Ms. SEBELIUS. Yes.

Mr. MURPHY. Also, of those who have gone to the marketplace, the Federal and State marketplace but are not Medicaid, how many were previously uninsured but are now covered? Let me roll these out. How many were insured but had a plan canceled so they are covered? Do we have that kind of information? Is that things that we are able to get?

Ms. SEBELIUS. We may be able to get some of that from the insurance companies. We would not collect that specific information, sir.

Mr. MURPHY. And people are talking about whether or not the policy cost them less or more. Obviously, it is critically important to have the facts on this. Is there a way that your office, or is there anything built in where we can actually find out how many people are paying more, how many people are paying less?

Ms. SEBELIUS. Again, we will rely on companies because we are talking about formerly insured to——

Mr. MURPHY. They may switch a plan.

Ms. SEBELIUS. They may switch a plan. They may have paid something, but that is really going to be company data, not data that we would have. No one newly insured would have that comparison so it is—-

Mr. MURPHY. We have heard different opinions and it would be great if we had facts on this so that would be helpful. And of the demographics, when I talked to some people who were insurance brokers or agents, they are describing that many of those who are signing up are people who may have had some health problems, have seen some high costs already, and they are going to the marketplace to find some of the cost. And there is also groups who may be healthy, and they are seeing some price changes there, too. Obviously, if the health care—if the Affordable Care Act was designed to help those sign up who are not able to afford health insurance before, or who are having difficulty because they had some illness, will we have breakdowns based upon those factors?

Ms. SEBELIUS. Again, we will be able to tell you hopefully in the not too distant future, demographic breakdowns. Because we don't collect personal health information from anyone because there is no longer a preexisting condition, nobody is medically underwritten anymore which everybody was in the individual market. We won't be able to tell you who of the population is sick, or not sick.

Mr. MURPHY. The next item is the question on the questionnaire, the Federal questionnaire which asks people if they have a condition of a disability or mental health problem, or emotional problem.

I guess we could look at that data if people would check that box it would tell us something.

Ms. SEBELIUS. For Medicaid eligibility, sir, there is a, I think a question on pregnancy, and a question on disability.

Mr. MURPHY. Yes, yes.

Ms. SEBELIUS. And those are the only two questions because that may qualify someone of a different income category for Medicaid. So those are the only two, I think, health information that is collected, but we don't have personal health information collected.

Mr. MURPHY. OK, we will need to get those facts. You had mentioned you asked McKinsey about the readiness of the exchange for the October 1 launch. Did the White House encourage you to ask this, or was that a decision you made on your own?

Ms. SEBELIUS. We made the decision going forward.

Mr. MURPHY. And why was that?

Ms. SEBELIUS. I think it is prudent to invite people who have not been directly involved with building a product to take a look at their—get their assessment on how things are going, what the problems are, and do it enough in advance that hopefully you can take their advice.

Mr. MURPHY. I would love to know from you and follow up with you, what changed because of that report. Let me ask this: The President said that if people have suggestions to improve what is going on, he would like to know. I am wondering, you have been immersed in this for quite a while. Are there some recommendations you have for Congress of what we need to do to take care of some of the problems we are facing?

Ms. SEBELIUS. Well, I certainly think that we will know a lot as we complete this first year of open enrollment. I would love the opportunity to come in and discuss those with this committee and others. We are—this is, as you know, the final phase of the 3.5-year implementation that has been underway, and I would say that we know a lot about young adults that we didn't know then. We know a lot about some of the preventive care issues. As you say, mental health is going to be a part of this. So I think we will have a list to actually share with you, and we would love to work in a bipartisan fashion to actually fix the bill.

There is no question that a brand-new bill, you know, will take some amendments and hopefully move forward, but I would welcome that opportunity.

Mr. MURPHY. Thank you. My time is expired. I now recognize the gentlelady from Florida, Mrs. Castor for 5 minutes.

Ms. CASTOR. Thank you, Mr. Chairman. And Secretary Sebelius, I am very pleased to see all of the progress that is being made with HealthCare.gov. Reports from consumers, and recent enrollment numbers suggest that individuals using the Web site to obtain quality affordable health insurance are having a much smoother and more successful experience. Thank goodness.

Reading over the statistics from the new report, I was very surprised that the State of Florida is leading enrollment out of all of the States on the Federally-run exchanges because we have had so many political roadblocks. There has been so much misinformation. This is good news for Floridians and it makes me wonder what if the Web site had been working great right off the bat? These would

probably be doubled. So I know families and individuals have more time. We really want to push over the next few weeks, but you said they have 3.5 months?

Ms. SEBELIUS. That is correct, Congresswoman, and as you know, because you have been a key part of this, I think the assistance of not only key Members of the congressional delegations throughout Florida, but mayors, civic leaders, health care providers, navigators, assisters are stepping up and really getting information to people who desperately need it. Florida has one of the highest numbers of uninsured Americans in the country, and clearly, people are eager for information and welcome the opportunity to make some choices for themselves and their families that they have never had before.

Ms. CASTOR. In fact, I had one report yesterday that a local enrollment fair at a church, they signed up 50 individuals on Sunday. And then I have this email from the Tampa Family Health Centers, the two stories. Juana Rodriguez, a 63-year-old woman who has been without health insurance for 3 years stated: What a blessing to finally have insurance. She said this with a smile and replied how she was finally able to afford her medications for a preexisting condition. Her tax credit is $530, and she purchased insurance for just $35 a month. And then Robert Welch, a 29-year old single young man who had no insurance for the past few years. He works for a small business, and his employer was not able to afford private insurance. He was able to get a tax credit for $2,200. And his premium is $28. He was extremely pleased, and agreed to share his story, but he said he was too shy to speak in public. So Robert. We are sharing your story today, and I am grateful that now we can replicate his good-news story. But we have a long way to go.

Now, on his small business question, it—we are all a little bit disappointed that the shop, the small business Web site is not going to be up and running as early as we would have liked, but does that affect the tax credits that are available for small business owners, those tax credits that encourage small businesses to provide health insurance, or to help make it more affordable for their employees?

Ms. SEBELIUS. No, Congresswoman, it will not impact that. As you know, we had earlier suggested that at the Federal level, and this is different in some of the States, but at the Federal level, year one we would not be able to aggregate premiums and give employees of businesses under 50 a choice. That will happen in 2014. The tax credits are very much in place. We have, again, a process where we are working with agents and brokers which is a way that small business owners have gotten coverage traditionally.

Ms. CASTOR. And their accountants, because some are not very sophisticated. There are three or four employees, especially in a tourism field State. You know, a lot of restaurant owners.

Ms. SEBELIUS. But the tax credit this year will go to a 50 percent tax credit for eligible employers. It is a tax credit that did not exist before the Affordable Care Act. It has been at 35 percent. It rises to 50 percent, and we will absolutely be enrolling. We have thousands of applications for shops. We are working to get folks enrolled and shop is different than the individual market where business owners have a 12-month enrollment period because of the tim-

ing of plans, so shop owners, or small business owners will be able to enroll each and every month as their employee insurance comes up for renewal.

Ms. CASTOR. OK, and then they file for the tax credit when they file for their——

Ms. SEBELIUS. That is correct. In 2015, they would be eligible for that.

Ms. CASTOR. So planning now, if you are a small business owner looking into that, because I don't think that many small businesses understand that a very robust tax credit that is growing from 35 percent to 50 percent, might make a huge difference.

Ms. SEBELIUS. And the Small Business Administration has been a terrific partner in that effort. They are using their channels to do a lot of outreach and education.

Ms. CASTOR. Thank you very much.

Mr. PITTS [presiding]. Thank you, Madam Secretary.

The Chair now recognizes the gentleman from New Jersey, Mr. Lance, 5 minutes for questions.

Mr. LANCE. Thank you very much, Mr. Chairman. Good morning to you, Madam Secretary.

Ms. SEBELIUS. Good morning.

Mr. LANCE. My questioning will be in two parts. First, regarding the rule of law, and second, regarding the Medicaid expansion. Regarding the rule of law, I will be going into an exchange, if that is how I read the statute, even though I didn't vote for it, and hope that it is replaced, and those who work with me in our office will be going into the exchange. And I would urge other Members, for example, Senator Reid, that as I read the statute, that is the rule of law.

In answer to Ranking Member Waxman, you indicated, and I certainly agree with this, that the President decided on the transition policy even though the statute, as I read it, has requirements that begin on January 1st, 2014.

From your perspective, Madam Secretary, what is the statutory authority for the President to have announced the transition policy?

Ms. SEBELIUS. Sir, I think the statutory authority is the enforcement discretion which is available under the law to us, and the President has asked us to use our enforcement discretion to not pursue penalties against insurers who would voluntarily decide to allow a transition of individuals in a market plan to continue in that market plan. This defers to State regulators. They get the first call because they regulate the marketplace, and then insurers, there is no mandate to insurers. It is voluntary, but it allows them to take up that option.

Mr. LANCE. Thank you. So from your perspective, the ability of the President to do that is based upon enforcement discretion. I respectfully disagree with that. Thank you for answering the question.

Number two, and Mr. Barton did raise this, as I read the statute, there are subsidies for State exchanges, but not subsidies for the Federal exchange, and I presume that that was placed into the statute to encourage States to have their own exchanges; a carrot-and-stick approach. From your perspective, Madam Secretary,

what is the statutory authority for permitting subsidies for the Federal exchange?

Ms. SEBELIUS. Again, sir, I am not a lawyer, and I would defer to the Department of Justice for the statutory authority. I think the framework is that I am mandated by statute to pay the subsidies, and that I think the interpretation is both by the OMB, which is sort of the appropriation leader on this, and the Department of Justice that the authority is consented to even though it is not explicitly spelled out. But again, I am not the lawyer. I would defer to them.

Mr. LANCE. Thank you. Let me state, it is my legal position that the courts will rule against the administration in this regard, and obviously, this is now before the courts. In the 3.5 years since the ACA's passage, has the President ever proposed a legislative change to any aspect of the law?

Ms. SEBELIUS. Sir, I am trying to refresh my memory. I cannot answer that question, but I will——

Mr. LANCE. Certainly.

Ms. SEBELIUS [continuing]. Come back with an answer.

Mr. LANCE. It is my understanding that the President has never asked for any statutory change whatever, and he has made——

Ms. SEBELIUS. Well, I can tell you one that I do recall that I think has been in his proposals. We do have a provision involving State waivers of Medicaid expansion and then into the marketplace that is timed to start at 2017. He has suggested, and I think it is part of our budget proposal, that there actually—that date be accelerated so that States would have full authority. There are other provisions I think in our budget plan, not necessarily pieces of legislation, but coming through that way that we could get you enumerated.

Mr. LANCE. Thank you. And then finally regarding the Medicaid matter, I have great concerns that many who have signed regarding Medicaid expansion were eligible before, and I know you are not able to provide those figures today, but I would like, at an opportunity that is convenient for you, Madam Secretary, to have those figures because it is my belief that quite a few are—were already Medicaid eligible, and are not based upon the new law.

Mr. PITTS. The gentleman's time is expired. The Chair now recognizes the gentleman from Maryland, Mr. Sarbanes, 5 minutes.

Mr. SARBANES. Thank you, Mr. Chairman. I thank you Madam Secretary, for being here. You have been very stoic in the face of a lot of adversity over the last few weeks. You have accepted responsibility for which you, yourself, characterize as a failure in the launch of the Web site, but have obviously been aggressive in trying to improve the situation. The evidence that you presented today suggests that things are on the mend, and a lot more Americans are being able to access the government Web site which is the portal to affordable health care for them.

I think if you step back, the bigger story here is just there were previously millions of Americans who were essentially trapped in a world where they could not access health care. There was literally no options available to them. If they had a preexisting condition, even the substandard plans that were offered in individual market often did not provide any option for them.

So they didn't even have the opportunity to complain or face the challenges that now some of them are facing. But the fact that they are trying to access an option of affordable care, and yes, encountering some difficulties in having to push through those, et cetera, even that is progress, because before they didn't even have that chance. But I think it is important for us to keep that in perspective, and that is why, I think you said earlier, I heard someone say that, or maybe it was Chairman Waxman, that one of the common emotional responses for people when they actually can enroll is they break down in tears, because of their years of pent-up frustration, and not being able to access affordable care.

Ms. SEBELIUS. Well, Congressman, we know that again, in the individual market, which is the market that the new marketplaces are addressing, a large number—national studies show that it could be as many as 25 percent of people who tried to buy a plan were turned down totally. So no plan, at no price.

Mr. SARBANES. OK, right.

Ms. SEBELIUS. And then you have people who were individually medically underwritten, virtually everyone in the marketplace. And that is very beneficial if you are healthy and don't have any likelihood of a preexisting condition, and typically, if you are male. It is not very beneficial if you are not. And if you get sick along the way, or if you are diagnosed, you could be, again, medically underwritten going forward to eliminate the condition that you need the care for.

Mr. SARBANES. Right.

Ms. SEBELIUS. So the choices were somewhat limited to a lot of people.

Mr. SARBANES. The promise of this is to create a new normal for the American people where the option of getting health care is real, and that wasn't the way it was before for tens of millions of Americans.

Ms. SEBELIUS. Depending on where they worked. If you worked for a company, and the vast majority of large employers offered——

Mr. SARBANES. Then you had the access.

Ms. SEBELIUS. And you weren't medically underwritten and you weren't penalized based on age, you were in as long as your employment. But if you worked for yourself, if you were an entrepreneur, if you were a service worker and didn't have affordable coverage your options were greatly——

Mr. SARBANES. But even that system is going to be more rational going forward because as you eliminate discrimination based on preexisting conditions, you address the problems of portability that we saw before when somebody leaves one employer and goes to the next, those are all fixes that are going to improve the employer-based system as well.

In terms of the challenges, obviously the launch of the Web site was much more difficult than was expected, but there were always going to be challenges. There are going to be new challenges, there are things, you know, you look around the corner, there are going to be difficulties and challenges associated with some of the payment issues that are going to happen down the line. These were always going to be there. There were always going to be difficulties. This is a major, major structural change to the health care system

which is going to improve it eventually, but we have to anticipate that there are going to be difficulties and we have got to soldier through those. That is the American ethic, right, is you take challenges and you overcome them.

And then the last time comment I just wanted to make is I think one of the issues is that a lot of the people who are coming and finding new plans and maybe they have to pay a little bit more or maybe the deductible is higher in some instances, for example, but what they don't compare it against is the exposure they had under the old plans that maybe they never had the occasion to experience and so that is the apples-to-apples comparison we have.

Mr. PITTS. The gentleman's time is expired. We have 15 minutes left. We have seven members still to ask questions. We will go to 2 minutes per member. The Chair recognizes Dr. Cassidy from Louisiana for 2 minutes for questions.

Mr. CASSIDY. Thank you Madam Secretary. In your answer to Mr. Shimkus, did you really mean to say that the Affordable Care Act has not resulted in increased premiums for the nonsubsidized?

Ms. SEBELIUS. Sir, what I said is preventive care——

Mr. CASSIDY. No. No. Are premiums higher——

Ms. SEBELIUS [continuing]. Doesn't add to the cost of premiums overall in terms of the long-term health care costs. That is what our description was.

Mr. CASSIDY. So you are ascribing it to the preventive health care aspect.

Ms. SEBELIUS. That is what he asked me, that is what I answered.

Mr. CASSIDY. Now, Jonathan Gruber, one of the architects of this bill, has said that this bill is basically income redistribution. Now obviously though the taxes that are a trillion over 10 years but there is also the increased premiums people are paying for their policies if they are not subsidized.

Do you have an estimate of how much increase, what is the amount of increased taxes people—excuse me, increased premiums people are paying to subsidize others on the exchange?

Ms. SEBELIUS. No, sir, I don't, and I think you can only talk about increased premiums, and I think Dr. Gruber would be one to suggest that if you compare like benefits to like benefits——

Mr. CASSIDY. Let me go on. Danny from Baton Rouge is losing his coverage. He says that this is my apocalypse now. The company I have, my family coverage went up 371 percent. Monthly premiums for a family of four from $245 a month to 913 with a $4,000 deductible. Wow, I think Danny would like to choose his benefits as opposed to that.

Many small businesses, according to your office, are going to lose their benefits; as many as 66 percent of employers, according to your analysis, will lose their grandfathered status.

Do you think administration would support my employee Health Care Protection Act which would allow workers to keep their group health care plan they have now in 2014 and beyond?

Ms. SEBELIUS. Sir, as you know, the snapshot is not our office estimating anything. It was a description of the turnover that existed prior to 2010 in the individual and small group market, those statistics that you cited. And I think in, again, the small group mar-

ket, there are lots of plans that are grandfathered, there are other plans that are offering transition in early renewals, and we are watching that every day.

Mr. CASSIDY. Can I get an answer to my question? Will the administration approve the same law that is given for the individual that if a small business wishes to keep their policy, they would be allowed to do so?

Ms. SEBELIUS. The President's suggestion about a transitional policy applies to both the individual and the small group.

Mr. CASSIDY. Beyond 2014?

Mr. PITTS. The gentleman's time is expired.

The Chair recognizes Mr. Engel from New York 2 minutes for questions.

Mr. ENGEL. Thank you, Mr. Chairman. I just want to say that New York is a good example of what is possible when the Federal Government has a willing and enthusiastic partner in ACA implementation. And we have set up our own exchange, we have hospitals participating in the various delivery system reform. Our Medicaid program is expanding. States that have fought to make the law work for their citizens like New York are finding success.

Secretary Sebelius, I would like to know what your experience has been in States that have obstructed efforts, mainly Republican Governors, to implement the ACA compared to States that have adopted all of its measures? Are Americans experiencing an easier time obtaining affordable health care coverage in States that have their own exchange, and has the refusal of some States to expand Medicaid affected the rollout?

Ms. SEBELIUS. Well, I think that, Congressman, what we are seeing every day is Governors actually considering the Medicaid expansion. Some, as you say, in New York, California, others adopted very early on. We were pleased yesterday that the Governor of Iowa indicated an interest in moving ahead on Medicaid expansion. That was not certain. The Governor of Pennsylvania recently also indicated his interest in doing the same. So we are working actively with States around the country.

I think it is enormously difficult for consumers in States where there is no Medicaid expansion, they hear about the opportunity for affordable health coverage only to find out that they earn too less to qualify for a tax credit in the marketplace and really they have no viable option at all, and that I'm told by our navigators on the ground, our assisters, the people in community health centers is one of the worst conversations that they can have in this period.

Mr. ENGEL. Well, we speak with the Governor of Kentucky the other day. And he explained to us Kentucky generally a Republican State, where it is working really, really well, where you have a Governor who is a partner who wants to see it work, it can work, and it should work. And I hope that more Governors would continue to do what is in the best interest of their constituents rather than playing political games. Thank you.

Mr. PITTS. The Chair thanks the gentleman. I now recognize the gentleman from Kentucky, Mr. Guthrie.

Mr. GUTHRIE. Thank you. You just mentioned Kentucky. Eighty percent of the people signing up on our exchanges are on Medicaid. And it has been a concern of mine, I was in State government be-

fore. And Medicaid as a national program has 72 million people, and we are expecting an increase of 25 million over the next 10 years. And I do believe Medicaid is important for low income children, disabled, seniors that it was designed for, but do you believe Medicaid should be a program of last resort or has it become just its own insurance program as it is now?

Ms. SEBELIUS. Sir, first of all, I think the enrollment numbers are about 51 million, not 72. But also Medicaid has played I think a critical role for lower income Americans not only offering a wide range of health benefits but at a lower cost per capita than private insurance and that Medicare.

Mr. GUTHRIE. I actually don't want to be rude, but he has cut us down to a couple minutes so the question I want to get at though is your department has estimated that about 5 million Americans who have previously purchased insurance through their employer will move to Medicaid, and that is from the Office of OACT, the Office of Actuary, it is the number we got. And are you familiar with that, that we are looking at, over the next 4 years estimates of 5 million Americans who have employer-based insurance will move to Medicaid?

Ms. SEBELIUS. I am not aware of that. The Office of Actuary really is an independent office, but I can check into that.

Mr. GUTHRIE. It is a part of CMS.

Ms. SEBELIUS. I'm not familiar with that specific number.

Mr. GUTHRIE. That is just a concern because the estimate is it would be $20 billion in this group of people who previously purchased health insurance through their employer who will be moving into Medicaid because of the Affordable Care Act.

The question that Chairman Upton had about income, there is a question with Chairman Upton about income verification and residency verification. I know that is up to the States to do, but the States who don't expand Medicaid, the information right now, is it just trust the Federal Government's numbers, right? Right now that is what they are being asked to do right now?

Ms. SEBELIUS. Again, sir, we don't enroll anyone in Medicaid. What we do is look at income eligibility, and based on the State law, send that individual's name and the information that has been collected to the State. The State actually is the connection between the individual and Medicaid. Not the Federal Government.

Mr. GUTHRIE. But because of timing by the January 1st, they are going to have to just accept it.

Ms. SEBELIUS. Yes, and that is going on right now. The process. But we don't enroll in Medicaid we just——

Mr. GUTHRIE. But they have to take your data.

Mr. PITTS. The gentleman's time has expired. Thank you, Madam Secretary. The Chair recognizes Mr. Griffith 2 minutes for questions.

Mr. GRIFFITH. Thank you, Mr. Chairman. Secretary Sebelius let me just let you know that I agree with Representative Leonard Lance's legal reasoning on the matters that he brought up earlier in his testimony. I do find it interesting that when we're listening to my colleagues on the other side of the aisle when they talk about scare tactics, this is similar to what they said back in the summer and in September, when we were holding hearings because we

were hearing that the plan wouldn't be ready on October 1, and so I am just concerned that we are going to have some of that same kind of thing now that we are being attacked for asking questions. We are just trying to get the information. And it is not that we are interested in scare tactics or witch hunts, it is a matter of we are trying to get to the bottom of a lot of these problems that we are concerned about out there.

And obviously one of the tactics they said, well, this is all just political but you certainly have accepted responsibility and you don't believe that we caused the problems with the Web site, therefore making the public distrust it, isn't that correct?

Ms. SEBELIUS. I do not believe you caused the problems with the Web site, sir.

Mr. GRIFFITH. Thank you. Some of my colleagues implied maybe not that you, but somehow we are responsible for all of that distrust out there and I don't think that is accurate.

Also I don't believe that the Federal Employee Health Benefit plan is a skimpy plan. Some of the folks said that the reason that costs were going up is that people had skimpy plans. Well, I was previously on the Federal Employee Health Benefit plan, and my family is facing 117 percent increase out of our pocket, that is out of our pocket increase, to go on to the exchange here in DC, and so you don't think the plan you have is skimpy do you?

Ms. SEBELIUS. No, sir, I don't but as you know——

Mr. GRIFFITH. And you prefer to stay on that plan, don't you?

Ms. SEBELIUS. The new marketplace plan have some age rating that the Federal Employee Health Benefit program did not so you are going to see younger employees paying a lot less and older employees paying more.

Mr. GRIFFITH. That is one of the reasons—I'm running out of time. Let me say this, too, in regard to Medicaid. One of the problems that you are having is you are sending people to the States based on income alone. And in Virginia, most States they have an asset amount. In Virginia, it is only $2,000. So they may have sufficient income to—they may not have enough income but they qualify for Medicaid under income, but they don't qualify for Medicaid because they own a house. And I asked some experts on this previously and they said they have to choose whether they want their asset or whether they want the Medicaid.

Ms. SEBELIUS. Again, the State law and the State Medicaid enrollment officials will make the determination of whether that individual will be enrolled. When they present at the marketplace, based on 133 percent or less and in Virginia right now it would be based on a lot less because Virginia has not raised their Medicaid eligibility.

Mr. PITTS. Thank you, Madam Secretary.

Ms. SEBELIUS. We would make a determination and refer that name, and they make that——

Mr. PITTS. The Chair recognizes the gentleman from Georgia, Dr. Gingrey, 2 minutes.

Mr. GINGREY. Madam Secretary, I want to begin the question about the Medicaid program. My Governor, Nathan Deal of Georgia particularly wants an answer to this question and I am sure all the other 49 Governors would too. The American Affordable Care Act

force States, they force States to retain the eligibility requirements of Medicaid through the maintenance of effort provision going back to 2009.

With the expiration of these provisions, States will finally have the flexibility to tailor their Medicaid program to best address the health care needs of their Medicaid populations.

Now, this is the question. Will the Medicaid MOE, maintenance about to expire, for all States beginning on January 1, 2014?

Ms. SEBELIUS. Yes, sir.

Mr. GINGREY. Thank you. Madam Secretary, I want to ask you real quickly. In regard to eHealth plans, this company, California-based company, I think, 10 years old, we talked about it earlier in the discussion, I think they spent about $100 million developing their program allowing people to go onto their Web site and find plans, and yet we spent seven times that much reinventing the wheel.

Can you tell me why we didn't just use that technology or maybe some other Silicon Valley company to have a public-private partnership rather than starting over from scratch? And who made that decision?

Ms. SEBELIUS. Well, sir, I would tell you that while there are some comparisons with the eHealth situation, there are a number of features very different in the Federal Web site that were required eHealth doesn't determine citizenship eligibility, it doesn't identify the Social Security number. It doesn't——

Mr. GINGREY. But did you make that decision or was that made by someone else?

Ms. SEBELIUS. What decision, sir?

Mr. GINGREY. The decision to start over from scratch.

Ms. SEBELIUS. Well, I don't think they did start over from scratch. They actually, I think, along the way, adopted a number of the known technologies that were in place——

Mr. GINGREY. Let me ask you finally, I don't want to run out of time, how many times did you actually visit with the President since 2009 or 2010 when you came on board? How many personal visits did you have with him at the White House regarding the Affordable Care Act?

Ms. SEBELIUS. A lot.

Mr. GINGREY. Can you verify that?

Ms. SEBELIUS. Yes.

Mr. PITTS. The gentleman's time is expired. The Chair now recognizes the gentleman from Florida, Mr. Bilirakis, 2 minutes for questioning.

Mr. BILIRAKIS. Thank you, Mr. Chairman, I appreciate it. Thanks for holding this hearing.

Madam Secretary, in a proposed rule in November, CMS announced that they were considering increasing payments to insurance companies with sicker than average customers through the risk corridor program under section 1342 of the ACA. This program is supposed to be financed by insurance companies participating in the Exchange, but the proposal appears to put taxpayers on the hook. Specifically the rule states that, and I quote, "This proposed adjustment may increase the total amount of risk corridors pay-

ments that the Federal Government will make ,,, [and] reduce the amount of risk corridors receipts ..."

Did you, Madam Secretary, estimate how much more money taxpayers would have to pay to insurance companies under this proposed rule?

Ms. SEBELIUS. Sir, the risk corridor has always been a part of the Affordable Care Act and was anticipated for the first couple of years to be used for reinsurance and risk corridors for the new marketplaces. So we did put out a proposed rule. We talked about the fact that we would look carefully at what the enrollment is at the end of 2014 in order to determine going forward.

Mr. BILIRAKIS. Madam Secretary, did you estimate how much money——

Ms. SEBELIUS. We won't know anything about what that risk corridor looks like until we get more enrollment numbers.

Mr. BILIRAKIS. OK. The rule says, and I quote, "We cannot estimate the magnitude of this impact on aggregate risk corridors payments and charges at this time." I would like to get to the next question.

Do you think it is responsible to put taxpayers on the hook for insurance companies' losses in the Exchange? Do you think it is responsible to make these payments without even estimating the cost?

Ms. SEBELIUS. Again, sir, it will be based on what the risk pool looks like. We always knew that in the first couple of years, the market would be attracting some customers and not attracting others and that there would be some risk in what we are hopeful for as the Affordable Care Act continues into maturity is that we have mature pools. We knew the first years would need this kind of risk adjustment.

Mr. PITTS. The Chair thanks the gentlelady and now recognizes Mrs. Ellmers, 2 minutes for questions.

Mrs. ELLMERS. Thank you Mr. Chairman. Thank you, Madam Secretary, for being with us.

I have some specific questions to ask about some of the—essentially the promises that the President made to the American people as he was rolling out the idea of the Affordable Care Act. One of those promises being, if you like your doctor, you can keep your doctor, period.

Can you commit to the American people today that this is true and that they will be able to keep their doctor?

Ms. SEBELIUS. Congresswoman, I think that, as you well know, in the private market, networks change on a constant basis. The President is not overtaking the private health insurance market. There is——

Mrs. ELLMERS. You are absolutely right, but the promise that was made to the American people so that this piece of legislation, which is now law, was passed was that they would be able to keep their doctor, yes or no?

Ms. SEBELIUS. Again, most consumers will have the opportunity to pick and choose a network that continues their doctor. There is nothing in the law that has their doctor lost to them.

Mrs. ELLMERS. There is nothing in the law. But there are networks that are now very narrowed as a result of the law, is that not true?

Ms. SEBELIUS. Insurance companies make network decisions day in and day out. Any insurance company——

Mrs. ELLMERS. That is not the promise that the President made. Did the President not make that promise to the American people?

Ms. SEBELIUS. This is the private insurance market that changes networks on basically a daily basis.

Mrs. ELLMERS. Then why in the world, Madam Secretary, did the President make that promise to the American people?

Ms. SEBELIUS. I think the President was trying to assure people that the law did not require them to lose their doctor. They have a network to choose from——

Mrs. ELLMERS. No, I don't believe that he was reassuring the American people that they would not lose their doctor. I think he was reassuring the American people that if this law passed, that they would be able to keep their doctor. So therefore today you are basically saying no, that this is not the case.

Ms. SEBELIUS. I am saying that there is, again, this is the private insurance market where insurance companies develop networks and change them on a regular basis——

Mrs. ELLMERS. And the American people would be able to keep their doctor if they pay more, according to Ezekiel Emanuel.

Ms. SEBELIUS. They can choose a network where their doctor is available——

Mrs. ELLMERS. And pay more?

Ms. SEBELIUS. They can choose a plan where their doctor is not available based on the kind of premium, the kind of deductible, the kind of situation they have. They have a choice.

Mrs. ELLMERS. I see my time has expired so thank you, Madam Secretary.

Mr. PITTS. The Chair thanks the gentlelady.

That concludes our questioning at the present. Madam Secretary, we will have some follow-up questions we will send to you. We ask that you please respond promptly.

We have a couple of unanimous consent requests.

I would like unanimous consent to submit to the record a letter from Dr. Julie Welch, an emergency medicine physician and educator from Indianapolis. Without objection, so ordered.

[The information follows:]

Julie Welch, MD

12978 Rocky Pointe Road• McCordsville, Indiana 46055
E-Mail: jlwelch@iu.edu

Date: December 1, 2013

Dear Mr. President:

I am writing to bring to your attention a recent advertising campaign for the new Obamacare government health insurance marketplace through ProgressNow Colorado. The ad campaign was launched by ProgressNow Colorado and the Colorado Consumer Health Initiative for the online marketplace called "Connect for Health Colorado" in October 2013. The ads are housed on the website of Progress Now Colorado (http://doyougotinsurance.com).

The campaign is titled "Got Insurance" and is a play on the "Got Milk" phrase. But unlike the health benefits of milk, the "Got Insurance" ads do not universally advertise healthy choices; rather, many celebrate the unhealthy, high-risk behaviors of young adults. The ads of concern are referred to as "Brosurance," "Brosurance for the Ladies," or "Hosurance," by the media and depict keg-stands, alcohol consumption, and women picking up guys.

Many of the ads have gone viral on the Internet and social media. Although I have heard numerous comments from the public, I have not seen your administration take a stand one way or another on the messages being presented in this ad campaign. Silence can only be interpreted as complacence and acceptance. I, however, am neither complacent nor acceptant of the ads that overtly objectify women and promote high-risk behaviors. And as an emergency medicine physician, medical educator, woman, mother, and taxpayer I would like to express my concerns.

Although the ad campaign has expanded to pertain to a broader audience, I am concerned about the message conveyed in several specific ads. One of the ads, titled "Let's Get Physical," depicts a woman holding birth control pills and contemplating how she will get a guy to have sex with her. Five of the ads depict or blatantly celebrate alcohol consumption, titled "Brosurance," "Club Med," "Friends with Benefits," "Keg ER," and "Get Your Shots." What message are these ads sending to our young people and our children? As these ads go viral on social media, young people may think that keg stands and one-night stands are okay. Especially since they are being advertised in association with healthcare, Obamacare specifically.

Being an emergency department physician, health insurance ads should not glorify alcohol consumption, doing keg stands, drinking shots, or promiscuous sex. In the emergency department, cases of trauma, physical assault, sexual assault, and motor vehicle crashes are commonly associated with substance abuse, including alcohol consumption. In addition, alcohol consumption, for some patients, becomes a lifelong disease of alcohol addiction leading to serious health effects including hepatitis, cirrhosis of the liver, bone marrow dysfunction, esophageal varicosities, intestinal bleeding, and death. And it typically begins with partying as a young adult, a time when the message is "it's cool to drink" and "you have to drink to have fun." The message I want my patients and medical students to understand is the opposite message I see in these ads. In fact, many of these ads could be used to educate patients (including our teenagers) to the potential negative health consequences of high-risk behaviors. For instance, if you go to a party and do keg stands, then hook up with a girl because she is on birth control pills, what are all of the negative outcomes you can foresee? Having health insurance will be the least of your worries the next morning.

The ad I am most concerned about is "Let's Get Physical." (I have included a copy with this letter.) It depicts a young woman hold a packet of birth control pills standing next to a young man and reads: "OMG, he's hot! Let's hope he's as easy to get as this birth control. My health insurance covers the pill, which means all I have to worry about is getting him between the covers. I got insurance. Now you can too. Thanks Obamacare!" There is an *asterix at the bottom of the ad that reads in tiny print: "The pill doesn't protect you from STDs, condoms and common sense do that." The message from this ad is alarming in several ways and sends the wrong message to women, men, girls, and boys.

1. This ad objectifies women, making her the object of sex. This alone is the most damaging consequence of advertising such as this. This ad seriously harms the progress we have made in women's rights and the way in which women are depicted in the media. It is degrading and offensive.

2. Promiscuous sexual behavior has serious risks for a woman including increased risk of cervical cancer, transmission of sexually transmitted infections (STI), unintended pregnancy, as well as psychological aftermath.

3. Birth control pills do not protect against HIV, herpes, gonorrhea, syphilis, chlamydia, or other sexually transmitted diseases. And the small asterix message at the bottom of the ad does not out way the message put forth in the ad. In fact, using a condom does not eliminate the risk of STD transmission via other routes.

4. Birth control pills are not 100% effective in preventing pregnancy.

5. Birth control pills and reproductive health rights do not equal healthy sexual choices. This ad does not depict responsible reproductive rights. In fact, this ad seems to say that women with birth control pills are sexually promiscuous and just take them to hook up with a guy. This ad also seems to insinuate that now that she has birth control pills, the barriers to a having a sexual relationship are nearly gone. Just getting the guy into bed is all that's left.

6. Finally, what message does this ad send to men? Or teenage boys? That a female just wants to get "him between the covers"? I fear this ad could promote aggressive behavior towards women, especially if combined with the people in the ads doing keg stands and drinking alcohol.

In 2013, we are in an age when women make up 51% of the workforce and 50% of medical students. Women cannot be silent as advertising emerges that sends the wrong message about our healthcare choices and us.

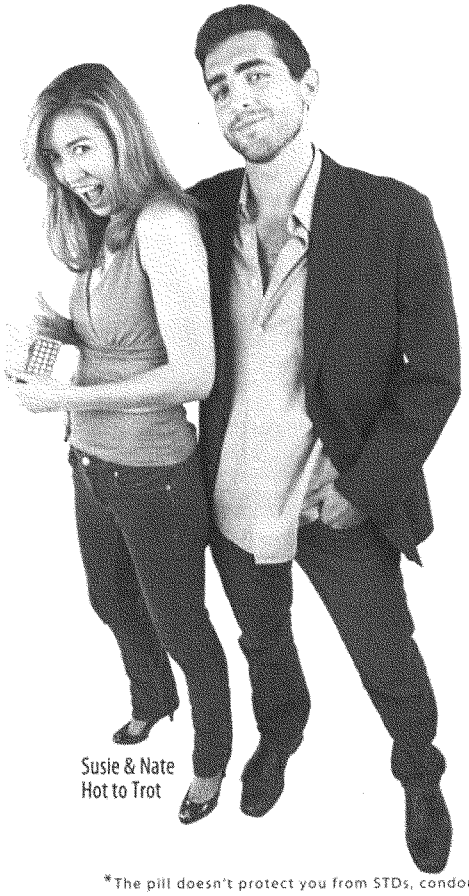
As a taxpayer, I am puzzled at why advertising campaigns for health insurance appear to promote high-risk behaviors? Do I as a taxpayer have to cover the consequences of these high-risk behaviors? Does the government agree with this? In an age when many insurance companies risk stratify your premiums based on smoking, obesity, blood pressure and cholesterol levels, where does the government stand on the high-risk behaviors in these ads? Will Americans have to share the costs?

The new health care plan is an opportunity to teach our populations about health responsibility, avoidance of risky behaviors, and promotion of good choices, because our country is shouldering it. Health insurance advertising should promote responsible behavior, no matter the source of the advertising. Please take a stand.

Sincerely,



Julie Welch, MD
Emergency Medicine Physician and Educator



got insurance?

Let's Get Physical

OMG, he's hot!
Let's hope he's as easy to get as this birth control. My health insurance covers the pill, which means all I have to worry about is getting him between the covers.* I got insurance.

Now you can too.

thanks obamacare!

#GotInsurance
doyougotinsurance.com

*The pill doesn't protect you from STDs, condoms and common sense do that.

Mr. PITTS. Dr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman. Dr. Gingrey referenced an offer from eHealth to the President to provide a platform for the market exchange, and I would like to submit his letter for the record, and I will make this part of a question for the record that I will do in follow up.

Mr. PITTS. Without objection, so ordered.

[The information follows:]

eHealth®

Gary Lauer
Chairman & CEO
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October 29, 2013

President Barack Obama
The White House
Washington D.C.

Dear President Obama:

I am writing you as the CEO of the nation's leading health insurance exchange. We are a public company located in the Silicon Valley, California that has enrolled millions of individuals in affordable health insurance policies for over 13 years, approximately 40% of whom were uninsured before coming to eHealth. We are consistently first in Google/search engine results when you key in the words "health insurance."

I am a longtime supporter of the Affordable Care Act and have spoken publicly in favor of the legislation from the earliest days of the national debate.

Mr. President: We are ready to help you get this program back on track promptly, with the cooperation of the federal exchange, if you allow us to take over the shopping and enrollment process in all 36 federal exchange states – *without cost to the taxpayer.* While your staff is working hard to repair Healthcare.gov, with your support, we can be the stopgap that is needed.

Last year, eHealth had 20 million visitors to our website from across the nation, a substantial number of whom were between the vital ages of 18 and 34. Our website operates at the highest levels of Internet consumer availability and reliability.

We have worked closely with Secretary Sebelius for the last year. To her credit, she issued a highly consumer-protective regulation allowing eHealth and other private sector health insurance websites to enroll lower income tax-subsidy eligible people, and in August of this year, the Centers for Medicare and Medicaid Services signed an agreement with eHealth allowing it to assist the federal exchanges with the shopping and enrollment process.

I would appreciate an opportunity to meet with you in person to discuss my offer and work with you toward a solution that better serves our country.

Sincerely,

Gary Lauer
Chairman and CEO, eHealth

Mr. PITTS. Ranking member has a unanimous consent request.

Mr. PALLONE. One is from my constituent in Piscataway, Anthony Wiehl, that I referenced. Another is the one that Ms. Schakowsky referenced. These are the different individuals impacted by the ACA.

Mr. PITTS. Without objection.

Mr. PALLONE. And then there is a third one from Ms. Schakowsky.

Mr. PITTS. Without objection, so ordered.

Thank you, Madam Secretary, for your patience for responding to all of our questions. I remind members they have 10 business days to submit questions for the record, and that means they should submit their questions by the close of business on Tuesday, December 31st. Another important hearing. Thank you, Madam Secretary, for your indulgence. Without objection, the subcommittee is adjourned.

[Whereupon, at 12:19 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115
Majority (202) 225–2927
Minority (202) 225–3641

January 13, 2014

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20101

Dear Madam Secretary:

Thank you for appearing before the Subcommittee on Health on Wednesday, December 11, 2013, to testify at the hearing entitled "PPACA Implementation Failures: What's Next."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on Tuesday, January 28, 2014. Your responses should be e-mailed in Word format to Sydne.Harwick@mail.house.gov and mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C., 20515.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

Secretary Sebelius Questions for the Record
House Energy & Commerce Subcommittee on Health
December 11, 2013

The Honorable Michael C. Burgess

1. **On November 27, 2013, CMS published a final rule for CY for physician payments, hospital outpatient and ambulatory surgical center payments. The final rule included a cut to epidural injections: a 36% reduction for physician payment and 58% reduction for procedures performed in an office setting. However hospitals will be reimbursed at $669.90 for the epidural procedure performed in the hospital setting.**

   Has CMS assessed how the inconsistent payments across settings could affect beneficiary access to epidural injections, especially interventional pain management services?

   Answer: The calendar year (CY) 2014 Physician Fee Schedule Final Rule with comment period continued our implementation of the misvalued code initiative in which certain codes are reviewed to determine if they are appropriately valued. Part of our misvalued code review for that rule resulted in reductions in payment for four epidural injection codes. These reductions are based upon data on the time it takes and the resources used in furnishing the service. In making these reductions, we considered information from the American Medical Association Relative Value Scale Update Committee (RUC). The physician payment when the procedure is furnished in the office was reduced for these services between 35 and 56 percent (compared to payment for the prior year). When furnished in a hospital or an Ambulatory Surgical Center, the physician payment is also reduced but by a lesser amount (17 to 33 percent).

   The higher payment for epidural injections to hospitals is due, in part, to the different statutory basis for each fee schedule and to the different structures of the physician fee schedule and the hospital outpatient prospective payment system (OPPS). For CY 2014, we finalized a significant increase in the number of packaged services in the hospital outpatient settings, including laboratory services and services always performed with a primary procedure such as additional injections furnished in the same session. The OPPS also does not make separate payment for low cost drugs and biologicals. The epidural injection codes are included in hospital outpatient payment groups that experienced an increase in payment as a result of our final packaging policy. Hospitals will receive higher payment for these outpatient injections than they did last year, but will not receive a separate payment for a number of other items and services for which a physician office would receive a separate payment. For instance, some drugs used for these injections are packaged for the OPPS payment to hospitals while physicians would be paid separately for these drugs and for the administration of the epidural injection, and for the office visit.

   We believe the physician payments are appropriate based upon our estimates of the resources used in furnishing the services in the physician office and our usual methodology and thus do not believe these reductions will affect patient access.

2. **Did CMS consider the recommendations in the MedPAC report to Congress in June 2013 entitled, "Medicare and the Health Care Delivery System," in which they advocate for multiple differences across ambulatory surgery center services with hospital outpatient services and the other office-based services with outpatient prospective payment system (OPPS) schedules?**

   Answer: There are different statutory frameworks for each payment system and each one is structured differently. CMS is aware of the MedPAC recommendations and believes that implementing the MedPAC June 2013 recommendations would require a statutory change.

The Honorable Ed Whitfield

1. **CMS posted the CY2014 final rules for physician payments, hospital outpatient and ambulatory surgical center payments on its website on November 27, 2013, for the new rates to be effective January 1, 2014, a day before Thanksgiving. Included in this final rule was a draconian cut to epidural injections with a 36% reduction for physician payment and 58% reduction for procedures performed in an office setting.**

   What type of evidence was used to determine these payment rates?

   Answer: These changes in the payment rates for epidural injections in the office setting were made as part of our efforts to improve payment accuracy by reviewing potentially misvalued codes. We began this initiative in response to concerns raised by Congress, the Medicare Payment Advisory Commission and others. Potentially misvalued codes are reviewed with input from the American Medical Association/Specialty Society Resource-Based Relative Value Scale Update Committee (AMA RUC) and public stakeholders. Each year since 2009, we have identified codes for review by looking for codes with specific attributes, such as those originally valued as inpatient services but that are typically furnished on an outpatient basis, services frequently billed together in one encounter, and high expenditure services that have not been recently reviewed.

   CMS has adopted a process to consider and, as appropriate, revise values for codes that are considered as part of the potentially misvalued codes initiative. Under that process, we establish values for misvalued codes on an interim basis in the final rule subject to public comment. We consider public comments on the interim final values received in response to the final rule, and respond to those comments in the final rule for the following year. In accordance with this process, we have established interim final values for these epidural injection services. The comment period on these values will close on January 27, 2014. We will consider public comments in establishing values for the codes in the Physician Fee Schedule (PFS) Final Rule for CY 2015.

   In our CY 2012 PFS Final Rule with comment period, we identified epidural injections as a high expenditure service that had not been recently reviewed. We used the survey times submitted by the AMA RUC, which were based on surveys of a sample of physicians who furnish the service, and recommended practice expense inputs to establish interim final

values for the epidural injection code family in the CY 2014 PFS Final Rule with comment period. The interim final revised work and practice expense values established in the CY 2014 PFS Final Rule with comment period reflect the reductions in time required to furnish the service as a result of the surveys submitted with the AMA RUC-recommended values and the expectation that reductions in the time required to furnish the service reasonably results in reductions to the work and practice expense values associated with the service.

CMS understands that this change in the physician fee schedule has resulted in CY 2014 payment reductions for the epidural injection services when furnished in the physician office. However, we believe that it is critical to continue to refine Medicare payments to more accurately pay for physicians' services. We intend to address public comments on these and other interim value codes adopted in the CY 2014 PFS Final Rule with comment period in the CY 2015 PFS rulemaking process.

2. **Did CMS look at what impact this proposal would have on patient's access to care?**

   Answer: We believe the physician payments are appropriate based upon our estimates of the resources used in furnishing the services in the physician office and our usual methodology and thus do not believe these reductions will affect patient access. We note that the payment rates in 2014 for epidural injections in the physician office setting are interim final values established by CMS. There is a 60-day comment period on these values which will close on January 27, 2014. We will consider and address the public comments we receive, including any comments on patient access to these services, in establishing the final values for the codes in the PFS rulemaking for CY 2015.

<u>The Honorable Cathy McMorris Rodgers</u>

1. **The Medicare Advantage program provides health insurance to more than 14 million seniors and individuals with disabilities (28 percent of all Medicare beneficiaries). People chose these policies because of the better service and additional benefits which are provided.**

   Despite people liking their plans, and despite being told that "If you like your plan, you can keep your plan. No matter what. Period." Obamacare includes more than $200 billion cuts to the Medicare Advantage program, with many of the cuts beginning in 2014. The result of these cuts will eliminate some of the plans that patients like. USA Today reported that there will be 5.3 percent fewer Medicare Advantage Plans for beneficiaries to choose from beginning in 2014.

   Will you explain to my constituents, who like their Medicare Advantage plans, why they will not be able to keep them?

Answer: With Medicare Advantage enrollment at an all-time high and costs remaining stable, concerns that recent changes to the MA program would result in lower enrollment and higher costs now appear unfounded. Nationwide, over 15 million Medicare beneficiaries[1] are now enrolled in an MA plan. This is a 30 percent increase in enrollment since 2010, and enrollment is projected to continue increasing.[2] Plan participation continues to be robust with 99.1 percent of beneficiaries having access to an MA plan in their area. The average MA premium in 2014 is projected to increase by only $1.64 from last year, coming to $32.60.[3] At the same time, the average number of plan choices will remain about the same in 2014, and access to supplemental benefits remains stable.[4] Additionally, since passage of the Affordable Care Act, average MA premiums are down by 9.8 percent.[5]

2. **Just days before Thanksgiving, you issued a final rule (CMS-1450F) which reduces Medicare payments under the Home Health Prospective Payment System. As you know, this regulation is to implement a provision in Obamacare—section 3131.**

   You have previously stated this rule will cause "approximately 40 percent" of all home health agencies nationwide to suffer net losses and face bankruptcy.

   In my home state of Washington, it is projected that 34 (of 56, or 61 percent) of home health providers who serve over 24,000 Washington seniors will go bankrupt and 5,581 people will lose their job.

   At a time when our nation continues to experience a tenuous economic recovery and the number of homebound seniors continues to increase, will you please provide a justification to my constituents why their access to home healthcare services is being scaled back or eliminated?

   Answer: The rebasing you reference is required under section 1895 of the Social Security Act and we do not have the authority to rescind or delay rebasing once implemented. In the CY 2014 Home Health PPS Final Rule (78 FR 72256), we estimated that approximately 40 percent of home health providers will have negative Medicare margins in CY 2017. We further noted that of the approximately 40 percent of home health providers predicted to have negative Medicare margins, 83 percent already reported negative Medicare margins in 2011. Therefore, the vast majority of home health agencies with estimated negative Medicare margins in CY 2017 had negative Medicare margins before the rebasing efforts finalized in the CY 2014 Home Health PPS Final Rule.

   In its March 2013 Report to Congress,[6] MedPAC stated that during the interim payment system (1997–2000), when payments dropped by about 50 percent in two years, many

[1] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Contract-and-Enrollment-Summary-Report-Items/Contract-Summary-2013-11.html?DLPage=1&DLSort=1&DLSortDir=descending
[2] 2013 Trustees Report pp. 166, 198. http://downloads.cms.gov/files/TR2013.pdf
[3] http://www.hhs.gov/news/press/2013pres/09/20130919b.html
[4] http://www.hhs.gov/news/press/2013pres/09/20130919b.html
[5] http://www.hhs.gov/news/press/2013pres/09/20130919b.html
[6] http://www.medpac.gov/documents/Mar13_EntireReport.pdf

agencies exited the program. However, new agencies entered the program (about 200 new agencies a year) and existing agencies expanded their service areas to enter markets left by exiting agencies. This is due in part to the low capital requirements for home health care services that allow the industry to react rapidly when the supply of agencies changes or contracts. MedPAC reviews found that access to care remained adequate during this period. In addition, since their 2011 Report to Congress, MedPAC has consistently recommended accelerating the rebasing of home health payments by phasing-in these adjustments over 2 years instead of 4 years.

In the economic impact assessment section of the CY 2014 Home Health PPS Final Rule, we estimate that HHAs will experience an overall 1.05 percent decrease in payments in CY 2014. However, we note that estimated payments to providers in the Pacific census region (of which Washington is included) are actually estimated to increase 0.34 percent in CY 2014. While we do not anticipate significant negative impacts of this rule, we note that, under section 3131(a) of the Affordable Care Act, MedPAC will conduct a study on the rebasing implementation, which will include impact analysis on access to care and quality outcomes, and will submit a Report to Congress. CMS is committed to closely monitoring the effects of these payment adjustments on beneficiaries' access and quality of care.

The Honorable H. Morgan Griffith

1. **The National Academy of Sciences (NAS) peer review committees, that are examining the Report on Carcinogens (RoC), are expected to release their reports in August-September, 2014. U.S. EPA, in responding to the recommendations in the NAS Formaldehyde Report (2011) for significant reforms to its IRIS assessment process, has increased opportunities for public input into both proposed enhancements and how they should be implemented, including a public stakeholder meeting in September 2012 as well as initiating bimonthly meetings on the IRIS process. These initial efforts are helpful as EPA awaits the formal report on the NAS IRIS Process Review. In responding to any reforms to the RoC program recommended by the NAS committees, will you agree to solicit and consider public comment on your Department's response?**
2. **Will the NTP review the NAS IRIS Process Review Report to consider adoption of the conclusions and recommendations identified by the panel?**
3. **Will you agree to provide regular reports to this committee regarding the implementation of any RoC reforms made in response to the recommendations of the NAS committees?**

Answer to Qs 1-3: The Joint Explanatory Statement (JES) for the Consolidated Appropriations Act, FY 2012 instructs the Assistant Secretary of Health "to contract with the National Academy of Sciences (NAS) to conduct a scientific peer review of the 12th Report on Carcinogens (RoC) determinations related to formaldehyde and styrene. Included in the review should be all relevant, peer-reviewed research related to both formaldehyde and styrene." Consistent with the JES, the NAS Statement of Task for the two review committees specifically provides that they are to undertake a scientific peer review of the listings for formaldehyde and styrene in the 12th RoC Notably, following publication of the

12th RoC in June 2011, the Department solicited and considered public comment on proposed revisions to the RoC review process, which were announced on January 11, 2012,[7] and have been implemented for purposes of developing the forthcoming 13th RoC. The changes are intended to enhance transparency and efficiency of the RoC review process, while maintaining critical elements of the existing process including external scientific and public involvement, scientific rigor, and external peer review.

Once released, the National Toxicology Program (NTP) will review the NAS IRIS Process Review Report and would consider any information that may be helpful in further strengthening its RoC review and listing process in the future. Any future changes to the process would likely follow NTP's normal procedures, which include soliciting public comment, gathering input from the NTP Board of Scientific Counselors, and announcing any final changes in the *Federal Register*. Should additional changes be announced in the future, the NTP would be pleased to provide the Committee with an update.

4. **Because this is the very first review of the Report on Carcinogens ever undertaken by the NAS, will you agree to commission additional NAS expert reviews to provide continuing guidance and feedback on the scientific validity of the RoC and other assessments prepared by the National Toxicology Program?**

Answer: The RoC process is designed to include multiple opportunities for input from scientific experts, as well as the public at large. These opportunities include initial and final review by the NTP Board of Scientific Counselors, review by peer review panels selected for expertise on substances under review, interagency review by Federal scientific experts, and review by the NTP Executive Committee. The NTP works hard to ensure that the scientific rigor these experts provide to the review process are weighed against the statutory mandate to publish the RoC every two years and the importance of providing timely health information to the public. By contrast, the current NAS reviews for 2011 styrene and formaldehyde listings requested in the JES for the Consolidated Appropriations Act, FY 2012, are not yet completed and are expected to take 24 months each at an additional cost of $1 million. While we plan to review the committees' reports on styrene and formaldehyde carefully, it is unlikely that NAS review of future RoC listings would be feasible under ordinary circumstances, given their time and expense when weighed against the Department's statutory mandate.

[7] More information on revisions at http://ntp.niehs.nih.gov/go/rocprocess

